ADDENDUM TO THE
HIV PREVENTION PLAN

SAN FRANCISCO 1998

SAN FRANCISCO
PUBLIC LIBRARY

REFERENCE
BOOK

Not to be taken from the Library

Addendum to the

San Francisco HIV Prevention Plan

1998

Developed by the

HIV Prevention Planning Council

A Community Planning Body funded by
the Centers for Disease Control and Prevention

Cooperative Agreement No. U62/CCU902017

In Partnership with the

Department of Public Health, AIDS Office

Prepared by
Harder+Company Community Research
March 1998

SAN FRANCISCO
HIV PREVENTION PLANNING COUNCIL
MEMBERS
1997

Chata/Ronnie Ashley — Community Co-Chair
Ellen Goldstein — Community Co-Chair
Gene Copello/Tracey Packer — Department of Public Health Co-Chairs

Barbara Adler
Marcos Bañales
Ahimsa Timoteo Bodran
Hector Carrillo
Gene Copello
Elizabeth Davis
Michael Discepola
Brenda Escobar
Roberto Garcia
Kevin Gogin
Vic Hernandez
Liz Highleyman
Jelousy Jiggetts
Valerie Kegebein
Sacul L'Adnbre
Jennifer Lorvick
Sonja Mackenzie
Lisa Moore
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Henry Ocampo
J. Colin Partridge
Dawn Passar
James Rapues
Joel Renya
Maria Rinaldi
Bethsaida Ruiz
Steven Sams
Sandy Simms
John Blake West
Thomas Zickgraf

COMMUNITY MEMBERS
1997

Christopher Smith
Lisa Bardaro

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
AIDS OFFICE

Barry Brinkley
Kristen Clements
A. Gene Copello
Brian Dobrow
Delia Garcia
Mitchell Katz
Keiko Kim
Valerie Kegebein
Betty Chan Lew
Tracey Packer
Mike Pendo
Stacy Vogan

PLANNING SUPPORT
TO THE HPPC AND ITS COMMITTEES

POLARIS RESEARCH AND DEVELOPMENT

Emily Coles
Ernest J. Fazio, Jr.
Marty Forst
Amalia Fernandez-Niewendorp
Mary Irvine
Rosa Osman

HARDER+COMPANY COMMUNITY RESEARCH

Lyn Paleo
Ellen Irie
Rick Green
Steven LaFrance
Claire Boddy
Rick Bradford

PROCESS EVALUATION TEAM

Kathleen Roe
Ruel Caneda
Pali Basi
Raquelle Caras
Cathleen Farrell
Cely Queiroz
Kevin Roe

ORGANIZATIONAL DEVELOPMENT AND TECHNICAL ASSISTANCE PROJECT SUPPORT

SUPPORT CENTER FOR NONPROFIT MANAGEMENT

Mike Allison
Christina Chan
Kit Durgin
Brenda Crawford

COMMUNICATION SCIENCES GROUP

Brian Tjugum

POLARIS RESEARCH AND DEVELOPMENT

Evelyn Crawford
Melinda Moore

HARDER+COMPANY COMMUNITY RESEARCH

Ron Strochlic

STD PREVENTION TRAINING CENTER

Stacy Vogan
Ed Mamary

AIDS OFFICE

Mike Pendo

Table of Contents

CHAPTER 1 - THE COMMUNITY PLANNING PROCESS

I. INTRODUCTION

The San Francisco HIV Prevention Planning Council's (HPPC) third year, 1996, was, in many ways, a watershed year. Not only did the HPPC completely revise the San Francisco HIV Prevention Plan, but it was during this year that the Plan was fully implemented. For the first time, the San Francisco AIDS Office issued requests for proposals and made funding allocations based on the Plan's recommendations for priority populations and interventions.

The HPPC continued full force during 1997, its fourth year of community planning. During this year, the Council continued to refine the Plan and Council operations based on its experience with implementation. This Addendum to the San Francisco HIV Prevention Plan chronicles the Council's work during this year. As an addendum, this volume does not stand alone. Rather, it highlights policy changes, new recommendations, and innovations in the Council's procedures made during 1997. For a complete understanding of HIV prevention planning in San Francisco, please refer to the 1997 San Francisco HIV Prevention Plan available from the AIDS Office.

During 1997, the HPPC's activities centered around two critical areas:

Refine the San Francisco HIV Prevention Plan in response to lessons learned from its first year of full implementation and continue to work toward the Plan's goals and objectives.

Council achievements in this area are fully discussed in individual chapters throughout this Addendum. These achievements include: development of a tool to assess the cultural competency of HIV-prevention providers; refinement of the priority-setting model used in the Plan; prioritization of interventions to be funded by CDC Supplemental Funds; creation of a comprehensive resource inventory; and a comprehensive review of literature in order to identify gaps in intervention-level evaluation.

1. Continue to improve Council operations to better support member retention and participation, as well as adhere to the values of parity, inclusion, and representation (PIR) which are the cornerstone of the community planning process.

   Work in this area is the subject of this chapter. Activities related to improving the Council's operations include: a policy change to allow selection of new members twice a year; adoption of a provision to permit proxy voting; new guidelines for public comment; an expanded orientation for new members; and the creation of a detailed document on roles and responsibilities. This chapter also summarizes decisions made during the year and discusses the general Council operations and membership.

1997	Planning Decisions and Recommendations
January	• Council receives orientation on roles and responsibilities of community planning • Council endorses direction of Roles and Responsibilities Task Force draft document in non-binding straw poll • Council approves bylaw changes
February	• Council elects new Community Co-Chair • Committees formed
March	• Committees elect chairs
April	• Council creates Supplemental Funding Task Force (SFTF) to make recommendations to the full Council for the use of CDC supplemental funds
May	• Council approves SFTF's recommended options for using the CDC supplemental funds in non-binding concept vote • Council votes to use CDC supplemental funds to fund unmet service needs • Interim DPH Co-Chair appointed to Council • Council approves bylaw changes
June	• Council votes to send letter of concurrence with AIDS Office's application for CDC Supplemental Funds • New members join the Council as provisional members
July	• Council finalizes recommendations to the AIDS Office for the use of CDC Supplemental Funds • Council finalizes recommendations to the AIDS Office for the use of unobligated funds
August	• Provisional members become full voting members
September	• Council votes to send letter of concurrence for the CDC Cooperative Agreement application
October	• Council votes to adopt new proxy voting procedures • Council votes to adopt new public comment protocol allowing public comment on each agenda item • Council approves direction of revised priority-setting model in non-binding concept vote
November	• Council votes to accept Roles and Responsibilities Document • Council approves direction of Cultural Competency Assessment Tool in non-binding concept vote • New members join Council as provisional members • New community Co-Chair elected for 1998-1999
December	• Council votes to recommend AIDS Office implement the Cultural Competency Assessment Tool
January 1998	• Council approves identified gaps in Intervention Level Evaluation • Council approves revised Priority-setting Model • Council approves Resource Inventory

II. COUNCIL OPERATIONS

The Council continued to meet twice a month throughout 1997. In general, the first meeting of the month was a regular business meeting, lasting three hours. The second meeting of the month was two hours in length. During these meetings, the Council heard presentations on a variety of prevention-related topics from various community groups, as well as attending to some routine business. A great deal of Council activity took place in between full Council meetings; Co-Chairs met regularly; the steering committee met almost monthly; and committees met as needed –generally once or twice a month.

Committee Structure and Tasks

Much of the Council's work is done in committee. At the beginning of the year, the Co-Chairs established five committees and assigned them specific tasks. These tasks were based on a review of the previous year's work, the Council's goals and objectives, and Council and community input. In several cases, committees revised their tasks through dialogue with the Co-Chairs. Additionally, two tasks forces were created to respond to specific issues that emerged during the course of the year. These are described below:

Membership Committee - The role of the Membership Committee was to review and adjust HPPC operating procedures, parliamentary procedures and public comment protocols. Membership Committee was also responsible for the orientation of new members, developing methods to recruit and train new members and improving retention, as well as ensuring the Council and its committees are representative of the San Francisco's diverse population.

Strategic Evaluation Committee - The Strategic Evaluation Committee worked to provide guidance in the planning and implementation of all three levels of the Plan's strategic evaluation: Provider level (Level 1); Intervention Research level (Level 2); and Prevention Indicator & Surveillance level (Level 3).

Linkages Committee - The Linkages Committee was charged with the task of identifying definitions of organizational cultural competency and developing an instrument for assessing HIV prevention providers' cultural competency.

Assessment Committee - The task of the Assessment Committee was to review and adjust the priority-setting model established in the 1997 HIV Prevention Plan, as well as update the Resource Inventory.

Steering Committee - The Steering Committee was comprised of HPPC Co-Chairs, the chairs of each of the other committees, and key AIDS Office staff. The Steering Committee reviewed progress on the goals and objectives, reviewed Council meeting agendas, and coordinated work between the committees.

Roles and Responsibilities Task Force - This task force developed a document outlining the boundaries of authority and responsibility related to the functioning of the HPPC and its

relationship with the AIDS Office in HIV prevention planning, resource allocation and implementation of the Plan's recommendations. Roles and Responsibilities also made recommendations about the implementation of the Roles and Responsibilities document.

Supplemental Funding Task Force - The Supplemental Funding Task Force was created to develop options and recommendations for the use of CDC Supplemental funding. Toward this goal, the task force developed criteria for identifying gaps in service left by current prevention contracts and worked in partnership with the AIDS Office to determine the substance of the proposal to be sent to the CDC.

Council Membership

The following table shows the composition of the Council at the end of the year. Council composition changed somewhat during the year, as some members resigned and new members were brought on during the year.

	Number of Members*	Percent of HPPC
Ethnicity		
African American	3	13%
Latino	5	21%
Native American	2	8%
Asian or Pacific Islander	3	13%
White	10	42%
Multi-ethnic	1	4%
Gender		
Female	11	44%
Lesbian	4	
Bisexual	2	
Heterosexual	5	
Male	14	56%
Gay	12	
Bisexual	1	
Heterosexual	1	
Transgender	0	0%
HIV-positive	8	22%
Youth (*under 24 years*)	4	11%
Representation		
Community-based Organizations	14	56%
Department of Public Health	3	12%
University of California, San Francisco	3	12%
San Francisco School District	1	4%
State Office of AIDS	1	4%
Unaffiliated Community Representatives	3	12%

** (Not all Council members provided information for every category.)*

Support for Members

During 1997, the Council instituted a number of new policies and procedures to better support members in their ability to work effectively on the HPPC. These refinements stemmed from lessons learned during previous years of Council functioning. The Membership Committee was responsible for developing these policies and presenting them to the full Council for comment and adoption.

Mid-Year Acceptance of New Members
Beginning in 1997, the Council began accepting new members onto the Council mid-year, as well as at the beginning of the year. In prior years, new HPPC members were brought onto the Council at the beginning of the year only. This resulted in a high number of vacancies toward the end of the year. As members left the Council for various reasons throughout the year, their empty seats would not be filled until the following January. In order to fill vacancies in a more timely manner, the Council began accepting new members twice a year. For the fourth year of planning, new members joined the Council in November 1996 and in June 1997. They began voting at the first meeting of January 1997 and August 1997, respectively.

Provisional Non-voting Period
In years prior, new members were able to vote as soon as they were accepted onto the Council. This posed difficulties for new members who were asked to make decisions without a complete understanding of the issues being discussed or Council process. With members beginning their term mid-year – while the Council was moving forward full speed – this problem was poised to become even more of a challenge.

To rectify this situation, the Council instituted a policy change. Beginning in 1997, Council members were appointed to a two-month provisional period during which they were not eligible to vote. This new policy gives new members the opportunity to observe Council proceedings and educate themselves about Council business before they are called upon to make decisions affecting the entire City of San Francisco. After the two-month provisional period, all new members automatically become full-voting members of the HPPC and serve a full 24-month term.

New Members Committee
Prior to 1997, orientation for new members took place during one all-day or half-day meeting. During this meeting, extensive information would be presented to new members covering everything from the philosophy behind community planning to Robert's Rules of Order. The orientation usually took place before new members had had the opportunity to attend a Council meeting, and new members often felt overwhelmed by the huge amount of information.

New members joining the Council at the end of 1997 were offered a more detailed orientation, spread out over several weeks. Rather than overloading members with information before they had begun participating, the Membership Committee established the New Members Committee consisting of a series of four meetings, each covering a different aspect of community planning. These meetings were set every other week during the new member's initial non-voting period on

the Council. Because new members were attending regular Council meetings during this same period, they were better able to understand how the information fit into the context of the Council's work. The New Members Committee also served as a place where new members could ask questions about issues or proceedings that came up during Council meetings. Unfortunately, attendance at these meetings was poor. The Membership Committee will investigate strategies for improving attendance before the next group of new members are brought onto the Council. Topics for each of the New Members Committee meetings are described below.

Session 1–The Epidemic: An overview of San Francisco's HIV epidemic focusing on recent trends, high-risk populations, and HIV-incidence estimates. This session included a discussion of the strengths and limitations of different types of epidemiological data.

Session 2–The Plan: An overview of the 1997 San Francisco HIV Prevention Plan, focusing on how its various components fit together and how members can utilize the document as a resource.

Session 3–Working in Groups: A discussion of different ways of valuing information, effective decision making for policy setting, and principles of negotiation.

Session 4–Roles and Responsibilities: An explanation of the various roles of Co-Chairs, committees, different AIDS Office staff, and support consultants.

Proxy voting*

Participation on the HPPC is time consuming and members have numerous competing personal, professional, and familial obligations. The demands of Council membership can be especially arduous to HIV-positive members. To facilitate participation, while easing the burden on Council members, the HPPC adopted proxy voting procedures during 1997.

With a proxy vote, a Council member designates another Council member to vote on her or his behalf, discusses the issue to be voted on before the meeting, and gives the proxy-designee full responsibility for voting. The difference between proxy voting and absentee voting is that in absentee voting, the absent member casts a vote prior to any discussions that may take place during the meeting. In proxy voting, on the other hand, the absent member entrusts his or her proxy to incorporate any new information that is presented and vote accordingly. A member being authorized to vote on behalf of another member may take into account new and additive information received at the Council meeting and vote as s/he decides, bearing in mind the discussion and wishes of the absent member.

* During the January 1998 Council meeting, the HPPC voted to comply with the Brown Act, which calls for increased public access to meetings. Because proxy voting is not allowed under the Brown act, this decision overrides the decision to adopt proxy voting procedures.

In order to avoid the unintended encouragement of absences, a number of restrictions apply to proxy voting. Each member is allowed to vote by proxy during one Council meeting in any given quarter. Proxy votes can only be used for votes that appear on the agenda, and they may be cast only when there is a quorum (50% of members plus one) physically present at a meeting of the HPPC. Proxy votes cannot be included in a quorum count, so by definition, proxy votes can never outnumber votes cast by members present in the room.

Only voting members can vote by proxy. Similarly, only voting members can hold a proxy vote for someone else. An individual may hold any number of proxy assignments, but may not cast more than two proxies on any given vote. Each Council member may choose only one person to be their proxy, though proxy assignments may be reassigned or rescinded at the member's discretion. Co-chairs cannot cast a proxy vote on behalf of another member.

There are two steps in using the proxy. 1) A member who wishes to use proxy voting must submit in writing to the Co-Chairs the name of the Council member to whom they assign their proxy vote. The proxy assignment will remain on file unless a member chooses to change or cancel the assignment. 2) Before a meeting which the member will miss, advance notification to the Co-Chairs must be made stating that the proxy on file will be voting on the member's behalf for a particular issue on the agenda of the meeting. Proxy voting assumes a discussion between the member who will miss the meeting and his/her proxy, therefore only issues on the agenda, and only votes which are authorized by the member will be accepted as proxy votes. If more than one vote is on the agenda, notification must include each specific issue for which the proxy vote is authorized. If the member notifies the Co-Chair by telephone, he or she must also submit notification in writing before the next Council meeting. In the event a member must leave a meeting before a vote is taken or arrive after a vote, similar notification to the Co-Chairs must be made.

When votes are recorded, proxy votes shall be recorded as such, distinct from regular votes. These policies for proxy votes apply to Council meetings only. Individual committees are responsible for establishing their own policies and procedures.

Governance

Public Comment

In recognition that community input and involvement are critical parts of the community planning process, the HPPC changed its rules governing public comment. Public comment is now accepted on every agenda item as well as during a separate ten minute period near the beginning of each meeting. For educational sessions, public comment is accepted during the entire question and answer period. In the past, public comment was only accepted during the separate period at the beginning of each meeting.

For each agenda item, the last portion of discussion before the vote is opened to include everyone who wishes to participate, including members of the public. No one is allowed to speak without first being called on by the Co-Chair, and comments are still limited to three minutes to allow input or questions from the largest number of people possible. Council

members cannot make a motion to close discussion if members of the public still have comments and the ten minute time limit has not run down.

Bylaw Changes

The Council made a number of revisions to its bylaws during 1997. Many of these were minor adjustments for clarification or to reflect restructuring in the organization of the San Francisco Department of Public Health. Other changes were made to facilitate smooth and equitable Council operations. (The current and complete bylaws can be found in Appendix 1 of this chapter.)

The following summarizes the changes which were made. Due to the revisions made in 1997, the bylaws now:

- Restrict membership to those who reside or work in the City of San Francisco, at time of appointment;
- Establish a "nomination pool," – a list of names of persons nominated during the previous selection cycle and still eligible for appointment to positions on the Council;
- Indicate that provisional membership terms will begin on November 1 of the preceding year or June 1; members have full voting privileges two months following the beginning of their provisional terms;
- Allow for a DPH Co-Chair who may not be in the HIV Prevention Planning, Policy, and Health Education Unit, but who does have HIV prevention responsibilities in the AIDS Office;
- Extend the retiring community Co-Chair's role beyond the two-year term, for an interim period lasting until the end of March, in order to mentor the incoming Chair;
- Stipulate that the Council must elect its new community Co-Chair from among individuals who have served at least one full year on the HPPC (by the end of January)* ;
- Identify the Prevention and Health Programs and Policy Branch Chief as the first-level arbitrator for disputes that cannot be resolved by the HPPC, its Co-Chairs and Prevention Unit staff of the AIDS Office+ ;
- Stipulate that, if a dispute cannot be settled with the assistance of the first-level arbitrator, an appeal will be sent to the director of the Department of Public Health.

III. ROLES AND RESPONSIBILITIES

The Roles and Responsibilities Task Force (which grew out of the Steering Committee) began work on *Roles and Responsibilities of the HPPC and the AIDS Office of the San Francisco Department of Public Health* in 1996. The purpose of this document is to outline the separate

---

* During the January 1998 meeting this bylaw was revised to stipulate that Council members need only have served six months on the Council in order to be eligible to serve as Co-Chair.

+ Due to organizational restructuring within the Department of Public Health, this position no longer exists. This bylaw will be modified to reflect this fact during 1998.

and shared responsibilities of the HPPC and the San Francisco Department of Public Health AIDS Office. (Refer to Appendix 2 for the complete *Roles and Responsibilities* document.)

Developing this document was an opportunity to clarify expectations, facilitate communication, and re-establish trust between AIDS Office staff and the leadership of the Council. HIV prevention planning in San Francisco should be a collaborative effort between the Department of Public Health and community representatives serving on the HPPC. By definition in the Centers for Disease Control and Prevention (CDC) Guidance for HIV Prevention Community Planning, the HPPC has final authority over the establishment of HIV prevention priorities. The Department of Public Health has authority over the implementation of these priorities; as an advisory body, the HPPC makes recommendations to the DPH. An effective city-wide prevention effort depends on clear communication and a partnership between the HPPC and DPH. These can be strengthened when the roles, and boundaries to those roles, are clarified within the partnership.

Key issues addressed in the document included the level of authority that the HPPC holds; the role of the HPPC in developing the plan to implement its recommendations; the expectations for communication between the HPPC and the Department of Public Health, and grievance procedures that the Council can use when its members perceive that the AIDS Office or Department of Public Health has violated trust or expectations.

It is the hope of the HPPC that this document will have utility to the Council in future years. The standards it sets are based on the experiences of the Council in the first four years of operations, particularly those related to implementing the Prevention Plan in 1996. Some of the lessons learned from these experiences can be passed to new members through this document, so that the work of the Council, and the pride that members take in that work, can be enhanced.

IV. SUPPLEMENTAL AND UNOBLIGATED FUNDS

Supplemental Funds

San Francisco was fortunate to receive an additional award of $719,000 in Supplemental Funds for HIV prevention from the CDC. The CDC awarded supplemental funds based on a formula, and each jurisdiction was invited to apply for the amount allotted to it. These funds augmented the CDC's Cooperative Agreement Funds for 1997.

The HPPC was responsible for forming recommendations for the use of these funds and working with the AIDS Office to determine the substance of the proposal to be sent to the CDC. The CDC required that a letter of concurrence (or non-concurrence) from the HPPC accompany the AIDS Office's application for the supplemental fund.

The HPPC formed the Supplemental Funding Task Force to develop recommendations to the AIDS Office for use of these additional funds. Working within the priority-setting criteria established by the Prevention Plan, the Supplemental Funding Task Force began by analyzing gaps in prevention services and proposing options for the use of the funds to the HPPC. The

Supplemental Funding Task Force presented the Council with an initial list of 13 options. Through an iterative process, these options were refined and narrowed, first to seven, then down to three. The following three options were included in the application to the CDC for Supplemental Funds:

1. ***Prevention Component of the Post-Exposure Prophylaxis (PEP) Program:*** San Francisco will be opening clinics to provide post-exposure treatment in the Fall of 1997. The clinics are expected to draw persons who have recently engaged in high risk activities. Funds were requested to pay for prevention counseling and follow-up services for these people but will not be used for the actual medical treatment. Funds also were requested to train prevention providers on the use of post-exposure treatment so they can better educate their clients. Education on Protease Inhibitors as primary and secondary prevention also will be part of the activity. Combined within this option is the priority to fund the education component between HIV and STD education. In this component, providers receive training in STD prevention and treatment so they can inform their clients about risks and early treatment options. Health education and training time will be supported through existing staff at the STD City Clinic.

2. ***Laboratory Costs of CTRPN Programs:*** This funding enables the laboratory to be reimbursed for tests provided by local providers in drug treatment sites and colleges and universities. To the extent possible, the laboratory will use this funding to analyze test specimens from additional providers.

3. ***Priority Behavioral Risk Populations and Interventions:*** The Council identified several behavioral risk populations and priority interventions best able to meet the prevention needs of these populations. The council then recommended the AIDS Office fund these unmet population needs and interventions with the supplemental funds. The priorities are shown in the table below.

BEHAVIORAL RISK POPULATION	PRIORITY INTERVENTION(S)*
HIGHEST **MSM-IDU, MSM/F-IDU, MSM, MSM/F** speed users all ages & ethnicities. Focus on specific speed use sub-cultures in Bars, Dance Clubs and Tenderloin.	**1. VBIO/PCM** - (extended VBIO/mobile PCM) **2. M** - both small and large (targets leather/Levi's community in and out of bars and speed users in dance clubs and other locations e.g., the Tenderloin)
HIGHEST **MSM, MSM/F** youth (<24), all ethnicities, men of color (specifically AfAm, NatAm & Latino youth 18-24)	*(Note: The following is a package)* **VBGO** (event focused) linked to **MSG** (not organized around HIV but around theater, writing workshops, etc.) linked to **M** - small (all interventions designed by and for youth)
HIGHEST **MSM-IDU, MSM/F-IDU, MSF/IDU** Male Injection Drug Users (includes bisexually acting and African Americans)	**IRRC** (mobile based and conducted where target populations congregate) Includes all ethnicities.
HIGHEST **MSM, MSM/F** - specifically targets Native Americans and African Americans	**1. IRRC** (for Native Americans and African Americans) Focus on extended encounters similar to PCM or IRRC. Ensure that it is mobile and intensive with a strong referral link to other services e.g., CTRPN that address co-factors) **2. M** (culturally appropriate small media)
HIGHER **FSM** risky partners, women of color	Assessment of Service Gaps in 1997. Gaps identified in assessment will be targeted in 1998.
HIGHER **MSM/F** closeted bisexually acting men who do not identify as gay or bisexual and do not access gay-identified services (particularly migrant Native Americans)	**M** (language appropriate large media such as billboards that discuss HIV risks - also small media for Native Americans) Intervention locations at community level.
HIGHER **MSM/F, MSF, MSM** Latino, immigrant, and migrant indigent population (includes transgendered pop) with other co-factors e.g., drugs or alcohol and poverty	**1. IRRC** (mobile-based to go where population is.) Multiple contacts to allow for addressing other co-factors affecting risk behaviors **2. M** (multi-lingual, culturally appropriate with accounting for literacy level)
HIGHER **FSM/F-IDU, FSM-IDU** women who inject	**IRRC/PCM** at needle exchange and other locations where population congregates (focus on referring or linking population to existing services).

Intervention codes: venue-based individual outreach **(VBIO); venue-based group outreach **(VBGO)**; single session group **(SSG)**; multiple session group **(MSG)**; media **(M)**; prevention case management **(PCM)**; individual risk reduction counseling **(IRRC)**; needle exchange **(NE)**.*

Because the CDC stipulated the funds needed to be awarded and used within 12 months, the AIDS Office, along with the HPPC, determined there was not sufficient time to issue a request for proposal. The AIDS Office, with input from the Council, developed a new process for awarding the funds. All HIV prevention providers who currently had contracts with the AIDS Office or had submitted a proposal to RFP 015 or 016 were invited to apply for the supplemental funds. The AIDS Office awarded the Supplemental Funds based on the Council priorities listed on the table on the previous page. AIDS Office staff kept the Council informed of the funding process and results.

Unobligated Funds

During the beginning of 1997, the AIDS Office determined that there were some funds from 1996 that were not spent and could possibly be used to fund some unmet needs. These are referred to as "Unobligated Funds." The CDC approved the use of these funds as long as the HPPC was involved in making recommendations.

The HPPC discussed priorities at several meetings. Presentations were made by staff of two projects on July 10, 1997 and the Council voted to send a letter of concurrence for these projects. At the July 24 and August 14 Council meetings, the HPPC developed priorities for the remaining funds. Stipulations related to these funds were that projects must be one-time only expenses and the funding must be spent by December 31, 1997. The following recommendations were made by the HPPC for the use of Unobligated Funds.

1. Detuned Assays: Detuned assays are an innovative way to use the standard HIV test, the ELISA blood test, to determine if HIV-positive persons have acquired the infection in the past four months. This technique provides a new range of prevention opportunities.

2. Completion of the Young Women's Survey: Funds were authorized to assist the Young Women's Survey (YWS) to reach their goal of sampling 500 young women. YWS is a study to assess HIV and STD rates among young women and to provide prevention counseling and referrals to them.

3. Media: The HPPC voted to authorize use of $100,000 to offset costs associated with interventions prioritized with Supplemental Funding: costs for media development and production to enhance the effectiveness of interventions prioritized by the HPPC through supplemental funds.

4. Peer Education Training: The HPPC supported the use of funds to develop and implement a one-time peer education training for youth through which youth could receive peer education certification.

5. Community Forums: These meetings would be "Town Hall" style meetings to facilitate community involvement with the HPPC.

For the first two priorities, a letter of concurrence was sent to the CDC from the HPPC and funding was spent on Detuned Assays and the completion of the YWS in 1997. A letter of concurrence with proposals 3 through 5 was sent to the CDC under separate cover. The AIDS Office was notified that San Francisco will be able to use the funds in the manner described above. It is anticipated that these funds will be made available to the AIDS Office in mid-1998 for use by December 31, 1998.

V. SUMMARY

The HPPC is now embarking on its fifth year of community HIV prevention planning. During years one and two, the Council developed its core recommendations regarding the prioritization of behavioral risk groups and interventions. During year three (1996) the Plan was implemented for the first time and year four was the HPPC's opportunity to revise implementation procedures based on lessons learned.

During 1998, the HPPC will work to educate the broader community about the content and purpose of the Plan. Equally important, the Council is developing new methods for inviting community input into the planning process. These ventures will strengthen community planning efforts by broadening the Council's dialogue with the community. Not only will these activities better inform San Franciscans about the existence and usefulness of the Plan, but, as the Plan is revised in future years, it will better reflect the needs and concerns of San Franciscans.

APPENDICES TO CHAPTER 1 - THE COMMUNITY PLANNING PROCESS

Appendix 1	HPPC Bylaws
Appendix 2	Roles and Responsibilities of the HPPC and the AIDS Office of the San Francisco Department of Public Health

Appendix 1

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
AIDS OFFICE

HIV PREVENTION PLANNING COUNCIL

BYLAWS

ARTICLE I - NAME

Section 1. The name of this body shall be the HIV Prevention Planning Council. (HPPC)

ARTICLE II - PURPOSE

Section 1. To develop, update, evaluate and implement San Francisco's comprehensive HIV Prevention Plan.

Section 2. To assess existing community resources to determine the community's capability to respond to the HIV epidemic.

Section 3. To establish priority HIV prevention needs by target populations and propose high priority strategies and interventions.

Section 4. To identify the technical assistance and capacity development needs of HIV prevention providers in the areas of program planning, intervention and evaluation for effective participation in the planning process.

Section 5. To consider how Counseling/Testing/Referral/Partner Notification (CTRPN); early intervention, primary care, and other HIV-related services; Sexually Transmitted Disease, Tuberculosis, and substance abuse prevention and treatment; mental health services; and other public health needs are addressed within the Comprehensive HIV Prevention Plan for San Francisco.

Section 6. To evaluate the HIV Prevention Community Planning process and the responsiveness and effectiveness of administrative mechanisms for addressing HIV prevention priorities and allocating funds for their implementation.

Section 7. To monitor the implementation of the priority goals, objectives, strategies and interventions contained in the comprehensive HIV Prevention Plan by HIV prevention providers, both Department of Public Health and AIDS Office contractors.

Revised and approved by the HPPC
October 23, 1997

ARTICLE III- MEMBERSHIP

Section 1. The membership of the HPPC, with the exception of an ex-officio representative of the State Office of AIDS, shall be restricted to persons who currently reside in or work in the city of San Francisco and shall consist of no more than thirty-seven (37) members representing

(a) the SFDPH AIDS Office
(b) the SFDPH Community Health Services Division
(c) the SF Unified School District
(d) the SF Division of Mental Health, Substance Abuse and Forensics
(e) experts in epidemiology, behavioral and social sciences, evaluation, research and health planning
(f) representatives of non-governmental/community organizations providing HIV prevention and related services and the affected communities
(g) individuals infected with HIV
(h) individuals affected by HIV

ARTICLE IV - NOMINATIONS

Section 1. **Governmental Representatives:** Representatives (no more than 10) of governmental organizations shall be nominated by their departments in response to a solicitation for membership issued by the Director of the AIDS Office to department heads. The Chief of the California Department of Health Services Office of AIDS shall designate a representative who shall serve in an ex-officio capacity.

Section 2. **Technical Experts:** Representatives (no more than 7) of experts in epidemiology, planning and the other categories listed in "f " (above) shall be solicited for membership on the basis of their expertise and community experience.

Section 3. **Non-Governmental Representatives:** Nominations for up to ten (10) representatives of non-governmental organizations providing HIV prevention and related services shall be solicited through a written appeal to all known prevention providers (whether or not they operate under contract with the AIDS Office).

Section 4. **Community Representatives:** Individual nominations for up to ten (10) positions will be solicited from infected and affected communities and defined populations (particularly youth, transgendered persons, people of color, and women) at risk for HIV infection.

Section 5. **Nominations Pool:** The names of persons who have been nominated as potential HPPC members shall be received by the AIDS Office and submitted for consideration under the provisions of Article V. Section 1. to the Membership Selection Committee. The Membership Selection Committee shall establish a list of persons eligible for appointment to positions which become available after the initial appointment process has been completed. This list shall remain active for six (6) months from its establishment.

ARTICLE V - APPOINTMENT

Section 1. Appointment of members to the HPPC shall be made jointly by the Director of the AIDS Office and the Director of the Department of Public Health in consultation with the Chief of the Programs and Policy Branch and the Chief of the Prevention Planning and Policy Unit of the AIDS Office, based on the recommendations of a Membership Selection Committee composed of the chair of the HPPC Membership Committee and at least two of the Co-Chairs of the HIV Prevention Planning Council and at least two of the Co-Chairs of the Mayor's HIV Health Services Planning Council.

Section 2. The term of office on the HPPC shall be twenty-four (24) months in addition to a two-month provisional period. At the end of their term, members may apply for appointment to a second twenty-four month term. After January 31, 1997, all terms will commence on January 1 and August 1 of each year.

Section 3. Termination/Resignation: Members who are absent (excused or unexcused) from two Council meetings within a two-month period shall be immediately advised that they are subject to termination at the discretion of the Co-Chairs. In the event positions become vacant between November 1 and August 1 of each year, new Council members shall be selected for a full twenty-four month period commencing on August 1. Should positions become vacant between August 1 and November 1, new Council members shall be selected for a full twenty-four month period commencing on January 1. Appointments shall be made according to the procedure outlined in Section 1 of this article.

Section 4. Status Change: Members whose residential or employment status changes after appointment to the HPPC, thereby making them ineligible for membership under the provisions of Article III, Section 1, shall be permitted to serve out the balance of their term.

Section 5. Exemption: In consideration of the need for representation of persons with HIV, those individuals shall be exempt from the above termination clause for absences due to illness. This exemption shall also extend to other HPPC members who have a life-threatening illness.

ARTICLE VI - OPERATING PROCEDURES

Section 1. Co-Chairs: Three (3) Co-Chairs shall be appointed to facilitate the operations of the HPPC: one (1) who shall be an AIDS Office staff member with HIV prevention community planning and policy experience appointed by the Director of the AIDS Office; and two (2) (excluding AIDS Office staff) community members elected by the HPPC membership. The community Co-Chairs shall be elected for a term of two calendar years on a staggered term basis. Responsibility for presiding at HPPC meetings shall be rotated among the Co-Chairs. By January 31st of each year, a new community Co-Chair shall be elected by the membership from among individuals who have served at least six (6) months as an HPPC member. In electing a community Co-Chair, the members shall strive for gender and ethnic balance.

Section 2. In the event a Co-Chair resigns from office prior to the end of the two year period, the membership shall elect another Co-Chair who will serve the remainder of the unexpired

term. A community Co-Chair who has reached the end of his/her two year term shall continue to serve the HPPC as an interim Co-Chair with full voting privileges for a period ending on March 31st during which time he/she shall serve as a mentor for the newly elected community Co-Chair.. A retiring AIDS Office Co-Chair shall serve as an ex-officio member of the HPPC with full voting privileges for a period ending on December 31st of the year in which he/she was replaced. The retiring Co-Chairs shall not be counted in the full HPPC membership count during this period of extended service.

Section 3. Parliamentary Procedure: The rules of parliamentary practice, as set forth in Robert's Rules of Order, shall govern all meetings of the HPPC except as otherwise provided herein. Where the Bylaws are silent on a procedural issue, Robert's Rules of Order shall serve as the formal guidance.

ARTICLE VII - MEETINGS

Section 1. Frequency of Meetings: Meetings of the HPPC shall be held on the second Thursday of each month. Any change in meeting schedule shall be announced at least seventy-two (72) hours in advance.

Section 2. Open Meetings: All meetings (except Executive Sessions) of the HPPC and its committees or task forces shall be open to any interested person.

Section 3. Special Meetings: Special meetings may be called and scheduled by the Co-Chairs or by six or more Council members. The place and time of such meetings shall be set forth in the meeting notice at least twenty-four (24) hours before the time of such meeting.

Section 4. Committees/Task Forces: The HPPC may create special committees and task forces to assist in the conduct of Council business. Such committees and task forces shall conduct open meetings which shall be announced at least seventy-two (72) hours in advance of such meeting(s).

Section 5. Quorum: A quorum of the HPPC must be present at any regular or specially scheduled meeting in order for the Council to engage in formal decision-making. A quorum is defined as more than one-half of the current membership provided that there are no less than eight (8) representatives of non-governmental organizations and/or affected communities present. All three (3) Co-Chairs shall be counted for purposes of a quorum.

Section 6. Proceedings: Council meetings will be tape recorded, with recordings available to Council members for their review. Meeting recordings will be held for a minimum of three (3) months. Written minutes will be made available prior to the following meeting and will be a public document.

Section 7. Voting: While the Council will strive for consensus, every official act taken by the Council shall be adopted by a majority vote. A majority vote shall be one half (1/2) plus one (1) of all Council members present for voting provided a quorum is present. An absent Council member may specify in writing (including by FAX) his/her opinion on an identified agenda item. This information will be shared with the Council by Council staff but will not be considered a vote.

The presiding Co-chairperson may vote only when breaking a tie vote. The remaining Co-Chairs shall retain their voting privileges unless required to assume the chair.

Section 8. Proxy Voting: It is the expectation of the HPPC that each member will be present at all Council meetings to fully participate as a responsible member of the community he/she represents. It is understood however, that due to health, business, or family matters, members occasionally may be required to be absent from Council meetings. At these times, the HPPC believes it is in the interest of the Council to establish the use of a proxy vote to those who are unable to attend the meeting. With a proxy vote, a council member designates another council member to vote on his/her behalf, discusses the issue to be voted on before the meeting, and gives the proxy designee full responsibility for voting. The difference between proxy voting and absentee voting is that in absentee voting, the vote is cast, and no new information which is provided at the meeting changes the vote. In proxy voting, the absent member entrusts his/her proxy to incorporate any new information and to vote accordingly. A member being authorized to vote on behalf of another member may take into account new and additive information received at the Council meeting and vote as he/she decides, bearing in mind the discussion and wishes of the absent member. Such an assignment of responsibility is therefore not to be taken lightly. It is expected that each HPPC member who chooses to assign a proxy to another member will choose a person with whom he/she feels a collaborative understanding of the issue(s).

Proxy votes can be used if a member needs to miss all or a portion of a meeting where a vote is to be taken. Proxy votes can be cast for any type of vote (i.e., concept votes or binding votes). Each member is allowed to vote by proxy during one Council meeting in any given quarter. The member may use his/her proxy for all votes on the agenda for that particular meeting, if all other conditions have been met. Proxy votes may be cast only when there is a quorum (more than half of the current membership) physically present at the meeting. Proxy votes shall not be included in a quorum count, so by definition, proxy votes can never out-number votes cast by Council members present in the room.

Only full voting members can vote by proxy. Similarly, only full voting members can serve as a proxy for another member. An individual member may hold any number of proxy assignments, but may not cast more than two (2) proxies on any given vote. Each Council member may choose only one person to be their proxy. Proxy assignments may be reassigned or rescinded at a member's discretion. The presiding Co-Chair at any meeting may not cast a proxy vote on behalf of another member.

Two steps are required in the proxy voting process: 1) a member who wishes to select a proxy must submit, in writing to the Co-Chairs, the name of the Council member to whom they assign their proxy vote; 2) before a meeting which the member will miss, the Co-Chairs must be given advance notification of the fact that the proxy on file will be voting on the member's behalf on an agenda issue at that meeting. Proxy voting assumes that the member who will miss the meeting has discussed the agenda with his/her proxy and has authorized the proxy to vote on specific issues. If more than one vote is on the agenda, the notification to the Co-Chairs must include each specific issue for which the proxy vote is authorized. If the member notifies a Co-Chair by phone, he/she also must

submit notification in writing before the next Council meeting. In the event a member must leave a meeting before a vote is taken (or will arrive after a vote) similar notification to the Co-Chairs must be provided.

When votes are recorded, proxy votes shall be recorded as such, distinct from regular votes. The proxy voting policy applies only to full Council meetings. Committees are responsible for establishing their own operating procedures.

ARTICLE VIII - CONFLICT OF INTEREST

Section 1. It shall be assumed that there is no conflict of interest in members as they work to develop and implement an HIV prevention plan. In deliberations regarding recommendations for the criteria to be used in the allocation of grant moneys and/or evaluation of specific programs and activities, should a conflict of interest arise, members with a potential or actual conflict shall declare the nature of their conflict and refrain from voting on that item.

ARTICLE IX - GRIEVANCE PROCEDURE

Section 1. In the event of disagreements and/or differences which cannot be resolved through discussions between the HPPC, its Co-Chairs and the staff of the HIV Prevention Planning, Policy and Health Education Unit of the AIDS Office in the prioritization and implementation of programs and services, the Director of the AIDS Office will serve as the first level arbitrator. Should it be impossible to resolve the issue(s) at this level, the matter(s) will be referred to the Director of the Department of Public Health who will attempt to arbitrate the matter and ultimately make a binding decision.

Section 2. In the event of continued disagreement with the final decision, an appeal may be filed directly with the Centers for Disease Control where an attempt will be made to mediate and manage the dispute and bring it to closure.

ARTICLE X - AMENDMENTS

Section 1. These Bylaws may be amended by the Council at any Regular Meeting by a two-thirds (2/3) vote of the members provided notice of proposed amendments has been published and distributed to the members no less than five (5) working days prior to the meeting.

Section 2. Members may propose amendments to the Bylaws at any Regular Meeting. Action on such proposed amendments will take place at the next regularly scheduled meeting.

Approved
October 23, 1997

Appendix 2

ROLES AND RESPONSIBILITIES OF THE SAN FRANCISCO HIV PREVENTION PLANNING COUNCIL (HPPC) AND AIDS OFFICE

INTRODUCTION

The purpose of this document is to outline the separate and shared responsibilities of the San Francisco HIV Prevention Planning Council (HPPC) and the San Francisco Department of Public Health AIDS Office (AO).

The Roles and Responsibilities Task Force (which grew out of the Steering Committee) began working on this document in 1996 with a review of the CDC Guidance governing HIV prevention community planning activities and of the HPPC Bylaws. Task Force members identified areas of responsibilities and, through discussion, clarified a new understanding of the shared and separate roles of the HPPC and AIDS Office in prevention planning. Forming this new understanding was not an easy job. Frustration, debate, compromise, and ultimately agreement characterized the sentiments of Task Force members while going through this process. Key points of fracture on the Task Force included the level of authority that the HPPC holds; the role of the HPPC in developing the plan to implement its recommendations; the expectations for communication between the HPPC and the Department of Public Health, and grievance procedures that the Council can use when its members perceive that the AIDS Office or Department of Public Health has violated trust or expectations.

From this process was created this document. It is the hope of the Task Force that this document will have utility to the Council in future years. The standards it sets are based on the experiences of the Council in the first four years of operations, particularly those related to implementing the Prevention Plan in 1996. Some of the lessons learned from these experiences can be passed to new members through this document, so that the work of the Council, and the pride that members take in that work, can be enhanced.

Developing this document was an opportunity to clarify expectations, facilitate communication, and re-establish trust between AIDS Office staff and the leadership of the Council. HIV prevention planning in San Francisco should be a collaborative effort between the Department of Public Health and community representatives serving on the HPPC. By definition in the Centers for Disease Control and Prevention (CDC) Guidance for HIV Prevention Community Planning, the HPPC has final authority over the establishment of HIV prevention priorities. The Department of Public Health has authority over the implementation of these priorities; as an advisory body, the HPPC makes recommendations to the DPH. An effective city-wide prevention effort depends on clear communication and a partnership between the HPPC and DPH. These can be strengthened when the roles, and boundaries to those roles, are clarified within the partnership.

A MEMBERSHIP

Members of the HPPC meet as a full Council at least monthly and meet in committees and Task Forces regularly. Committees are composed of HPPC members, staff of the AIDS Office, and community representatives. Recruiting, orienting, supporting and retaining members are critical elements of planning efforts. In previous years, as the Council experienced steady member attrition, it recognized that increased efforts are needed to retain and support members.

Responsibility for developing policy on composition of membership.
CDC Guidance outlines the composition requirements; AIDS Office staff of the Membership Committee monitors and regularly assesses the composition of HPPC membership and makes recommendations to the Selection Committee. (The Selection Committee composition is described in the HPPC Bylaws, Article V, Section 1.) As needed, the Membership Committee recommends revisions to Bylaws for adoption by Council.

Responsibility for developing/carrying out the process for selection of new members.
Article V Section 1 of HPPC Bylaws describes the process for the selection of new members. The Selection Committee recommends new members to AO/DPH. Appointments are made by AO/DPH and monitored by the Process Evaluation Team.

Responsibility for developing/carrying out methods to retain members.
The Membership Committee develops recommendations to better retain members, which the Council discusses and adopts. The Process Evaluation Team or AIDS Office staff tracks absences. Committee Chairs are encouraged to call members who do not show for committee meetings and/or seem to need support. Ultimately, all HPPC members have a responsibility to support each other and thus improve retention of members. The Process Evaluation Team explores barriers to participation and makes recommendations to the Co-Chairs and/or HPPC members regarding retention.

Responsibility for developing/carrying out methods for removal of members due to excessive absences.
Membership Committee develops recommendations as necessary for revising Bylaws about this issue for Council approval. Co-Chairs carry out the procedures, as outlined in the Bylaws (Article V Section 3).

B GOVERNANCE OF COUNCIL

The Council has effectively used the governing documents — both the HPPC Bylaws and the CDC Guidance — in establishing operating procedures and approaches to planning. These documents will continue to guide the Council in defining itself and its work.

Responsibility for developing, revising bylaws.
The Membership Committee develops recommendations for revisions; Council approves revisions.

Responsibility for developing and revising other documents pertaining to the operation of the HPPC.
The CDC Guidance and the HPPC Bylaws are the two primary documents that guide Council Operations. Additional recommendations for operating procedures are developed, as necessary. In general, the Membership Committee develops the bylaws and other documents which the HPPC discusses and adopts. Some documents or procedures are developed by other committees of the Council; for example, in 1996 the Steering Committee discussed choices of parliamentary procedures and procedures for operating committee meetings; in 1996/97 the Roles and Responsibilities Task Force developed this Roles and Responsibilities document. Documents describing procedures for the governance and operations of the Council are presented to the HPPC for discussion and adoption.

C MEETINGS - COUNCIL AND COMMITTEE

All Council members take responsibility for participating in meetings — both the full Council meetings and the smaller committee meetings — and continually seek to improve procedures to ensure parity and inclusion of members and input from the public. The Council is aided by the planning support it receives from AIDS Office staff and consultants. This planning support includes logistical support, technical support, and process evaluation/support. Members of the Task Force were in agreement about the responsibilities for operating Council meetings, but debated the responsibilities for the Planning Support. Relying on the CDC Guidance, the Task Force determined that Council members have a role in deciding how much and what type of support the HPPC needs, and the AIDS Office has the responsibility for selecting and overseeing the work of the Planning Support consultants.

Responsibility for determining the levels of funding, the scope of work, and the process for selecting contractors for planning support activities (logistical support, technical support, and process evaluation support).
The Co-Chairs, Steering Committee and AIDS Office staff who serve on committees jointly develop the suggested level of funding, the scope of work, and contractors' evaluation plan for planning support activities such as technical support, logistical support and process evaluation. The AIDS Office develops the contract and negotiates with the contractors. The AIDS Office receives input every 2 - 3 years from Council about the selection of contractors and selects the contractors.

Responsibility for selecting appropriate meeting space.
AIDS Office.

Responsibility for overseeing planning support consultants.
AIDS Office.

Responsibility for establishing agenda for Council meetings.
Co-Chairs develop agenda. When possible, the Steering Committee reviews/revises agenda. (The Steering Committee, composed of committee chairs, is usually formed in the second or third month of each planning year.)

Responsibility for determining the frequency and length of meetings.
Co-Chairs in consultation with Council establish the frequency and length of Council meetings. Committee Chairs in consultation with committee members establish the frequency and length of committee meetings.

Responsibility for facilitating Council meetings.
Co-Chairs facilitate Council meetings (and may delegate facilitation temporarily to another person). Membership Committee examines methods to operate meetings more smoothly with ongoing assistance from the Process Evaluation Team. Co-Chairs appoint a person to act as parliamentarian to advise on questions of parliamentary procedure. Technical support can be called upon or offer to re-cap issues under discussion as needed. The lead Process Evaluation consultant can be called on or offer to intervene when the process of the meeting has become difficult.

Responsibility for facilitating Committee meetings.
Committee Chair with support from Technical Support and Process Evaluation consultants.

Responsibility for developing improved ways to operate the Council.
Membership Committee, Co-Chairs, Steering Committee, with assistance from Process Evaluation and Technical Support consultants.

Responsibility for developing and revising effective ways for the public to have input into the planning process and HPPC's recommendations (see also Communication).
The Membership Committee develops/revises procedures for public comment and roles for community members on committees for discussion/adoption by HPPC.

D PLANNING ACTIVITIES

Critical to the planning process is establishing roles and responsibilities for the specific planning activities. Fortunately, the CDC Guidance lays out these responsibilities explicitly, and the Task Force had very little disagreement in this area.

Note: The term "Council" or "HPPC" includes all persons who are voting members. The term "Council+" or "HPPC+" includes community members and AO staff serving on HPPC committees. The clarification is important to this section since much planning work is conducted primarily on the committee level before it is brought to the full Council. Additionally, community members and AIDS Office staff can vote on the committee level but (with the exception of the DPH Co-Chair) not on the Council level.

Responsibility for determining what activities will be done by the HPPC each year.
Co-Chairs and AIDS Office with input from the Steering Committee, and Technical Support, after review of CDC Guidance and HPPC Goals and Objectives.

Responsibility for providing information and data for decision making.
Technical support consultants, AIDS Office, HPPC members.

Responsibility for reviewing data and using it to make decisions/recommendations.
Council+ members work in committees to develop recommendations which are approved by the HPPC. Additionally, the Council sometimes needs to review data to make recommendations.

Responsibility for assessing existing community resources.
A committee of the Council will provide guidance about the assessment of existing resources. AIDS Office with assistance of the Council, providers, and Technical Support collects information about existing resources.

Responsibility for conducting needs assessment to identify unmet needs.
Council+ members work in committees (with technical support as needed) to develop recommendations for needs assessments for approval by the HPPC. AIDS Office staff and technical support consultants conduct assessments, as feasible.

Responsibility for providing expertise and technical assistance to ensure that the planning process is comprehensive, scientifically valid, and community-appropriate.
Technical support consultants, AIDS Office staff, and Council+ members with this expertise.

Responsibility for identifying high priority strategies and interventions.
Council+ members work in committees (with technical support as needed) to develop recommendations which are approved by the HPPC.

Responsibility for identifying high priority target populations (establish prioritization process).
Council+ members work in committees (with technical support as needed) to develop recommendations which are approved by the HPPC.

Responsibility for making recommendations about linkage of HIV primary prevention, HIV secondary prevention, and other health programs.
Council+ members work in committees (with technical support as needed) to develop recommendations and implementation plans which are approved by the HPPC.

Responsibility for developing goals and objectives.
Council+ members work in committees (with technical support as needed) to develop recommendations which are approved by the HPPC.

Responsibility for preparing the plan.
Technical support consultants and AIDS Office, with review and adoption by the Council.

Responsibility for representing the plan and its priorities in the community.
Council+ members; AIDS Office.

E IMPLEMENTATION OF PRIORITIES AND RECOMMENDATIONS

At the heart of controversy in HIV prevention community planning, is the implementation of planning recommendations and the allocation of resources. Across the country, we have heard, community planning groups struggle with questions about the role of the community planning groups in determining resource allocation. There is no clear line between "planning" and "implementation"; instead, implementation starts with committee recommendations for change and continues until that change has been effected (often by prevention providers). Resource allocation is traditionally a responsibility of the health department, yet the AIDS Office and the Council acknowledges mutual interest in community and Council input into this responsibility, since it is during implementation that the recommendations of the council become manifest.

These issues came to the forefront in San Francisco in 1996 when the priorities and recommendations of the Prevention Plan were first implemented. Many lessons were learned from that experience, and the Task Force spent many meetings discussing this section. Because implementation is a process, and not a singular event, the line that divides the responsibility for implementation between the Council and AIDS Office will be dynamic. This section provides the basic responsibilities for implementation, but also critical are the processes of communication, accountability, and conflict resolution (described in later sections), because it is these areas that can build a partnership between the Council and the AIDS Office that transforms planning recommendations into actions.

Responsibility for developing resource allocation recommendations.

For cooperative agreement, State and City general funds, a resource allocation task force will be formed comprised of members of the HPPC and AIDS Office. The task force will make recommendations about issues such as gaps in priorities, general schedule for release of RFP, criteria for proposals, and criteria for review of proposals. The recommendations will not address specific agencies. The recommendations will be presented to the HPPC for adoption. The AIDS Office will use these recommendations in the development of the implementation plan. For sources of funds other than the aforementioned, the AIDS Office will develop a resource allocation plan and bring it to the Co-Chairs and Council for input.

Responsibility for finalizing the implementation plan.

Each HPPC committee should try to develop an implementation plan for the recommendations it makes. The AIDS Office and Co-Chairs will review resource allocation and other committee recommendations and the priorities in the Prevention Plan, and, from these, will develop an implementation plan each year. The implementation plan describes how the recommendations for the Council will be put into action, including mechanisms for funding and timelines. As much of the implementation plan will be presented to the Council as possible (without giving advantage to agency staff on the Council) for review and input. While developing the resource allocation implementation plan, the AIDS Office may convene an ad hoc task force as an advisory body.

Responsibility for writing the RFP.
AIDS Office.

Responsibility for reviewing the RFP.
AIDS Office and Council members without conflict of interest who are familiar with the proceedings and recommendations of the Council. Conflict of interest criteria have been established by the Department of Public Health.

Responsibility for reviewing the process for the review of proposals and guidelines for selecting reviewers.
Council+ members work in committees to develop recommendations for approval by the HPPC. These recommendations are forwarded to the AIDS Office for its consideration.

Responsibility for selecting reviewers.
AIDS Office.

Responsibility for reviewing applications.
AIDS Office, and a recruited panel of technical reviewers, AIDS experts, and Council members without conflict of interest serve on review panels.

Responsibility for conducting trainings and orientations on the Prevention Plan and HPPC priorities and standards.
Council members, AIDS Office, Technical Support.

Responsibility for conducting bidders' conference.
AIDS Office.

Responsibility for orienting reviewers of proposals.
Council members, AIDS Office, Technical Support.

Responsibility for selecting providers and awarding funds.
AIDS Office.

F OTHER IMPLEMENTATION ACTIVITIES

Several different types of implementation activities are outlined in this section. These activities are ongoing, but the mechanism for making recommendations may change from year to year. Most of these issues have not been controversial; however, the role of the Council in oversight of research and evaluation studies has been a point of fracture for the Council and AIDS Office.

Responsibility for assessing the degree to which the objectives in the Prevention Plan have been achieved.
AIDS Office and technical support with input from committees will compile a report on the status of progress on objectives and present it to the Steering Committee who will present it to the Council for discussion.

Responsibility for identifying technical assistance needs of community-based providers in areas of program planning, implementation, and evaluation.
AIDS Office (or its designee) gathers information; a committee reviews and discusses technical assistance needs and develops recommendations for filling the need. Council discusses and adopts recommendations.

Responsibility for ensuring that technical assistance is provided to meet the needs of providers.
AIDS Office (or its designee) gathers information; implements actions to provide technical assistance. Council reviews and discusses progress toward providing appropriate levels of technical assistance to prevention providers in the community.

Responsibility for ensuring the implementation of prioritized evaluation studies.
Council approves priority areas developed by committee; AIDS Office seeks funding for prioritized studies. To the extent possible, the AIDS Office participates in and coordinates with other funded studies. The Strategic Evaluation Committee's guidance and HPPC involvement on study advisory committees will be sought.

Responsibility of Council in oversight of research studies recommended by the HPPC.
Council reviews and adopts a list of studies prioritized by a committee. AIDS Office seeks funding for the prioritized research study. Each AIDS Office study shall have an advisory board, and the participation of at least one HPPC member will be sought on the advisory board. Regular reports to the HPPC will be made about the progress and findings of the study. Results will be reported to the Council and a summary included in the subsequent version of the Prevention Plan. If problems occur with the study and the resolution to the problems cannot be achieved through discussion with the advisory board, AIDS Office, and principal investigator, then the AIDS Office will make recommendations for study modification for Council discussion, explanation, and input.

G ADMINISTER AND COORDINATE FUNDS

There was little dispute that it is the AIDS Office's responsibility to administer and coordinate funds. The Council leadership would like Council members to have a role in monitoring prevention services and activities.

Responsibility for administering public funds (using the mix of funds that come to San Francisco).
AIDS Office.

Responsibility for monitoring prevention services and activities.
AIDS Office with invitation to HPPC members and other community members who have expertise with the populations and type of services being monitored and whose participation would not violate confidentiality.

H CDC COOPERATIVE AGREEMENT APPLICATION

It is the responsibility of the Council to review the AIDS Office application to the CDC to ensure that the funding request reflects the priorities contained in the Prevention Plan and to submit with the application a letter of concurrence or non-concurrence. A letter of concurrence indicates the extent to which the AIDS Office and HPPC have successfully collaborated in developing a comprehensive HIV prevention plan and agree upon the program priorities contained in the application. If the HPPC disagrees with the program priorities identified in the AIDS Office's application it should cite specific reasons for non-concurrence. The Letter of Concurrence is a check and balance in the planning and application process.

Responsibility for developing the application.
AIDS Office, with input from Co-Chairs on behalf of the HPPC, based on the recommendations of the Council.

Responsibility for evaluating the effectiveness of the application in addressing the priorities identified in the Prevention Plan.
Council and AIDS Office.

Responsibility for the letter of concurrence/non-concurrence.
Council members approve the letter; the Co-Chairs sign the letter.

I COMMUNICATION

One of the strongest messages coming from the Roles and Responsibilities Task Force is that greater emphasis should be placed on improving communication between the AIDS Office and Council than on attempting to define the "letter of the law" delineating each and every responsibility, since we cannot predict which issues or problems the Council will face in future years. Establishing regular, clear, honest systems of communication between the Council and the AIDS Office/Department of Public Health is the foundation of maintaining a sense of partnership that is critical in HIV prevention planning efforts.

Principles guiding communication between the AIDS Office and HPPC.
Members of the HPPC and Department of Public Health will strive for clear, honest communication. The following principles provide general guidance for good communication.

Respectful engagement - Communication will be conducted in such a way that respects all parties.

Inclusive - Decisions and recommendations will be made based on the broad involvement of people. To the degree practical, Council members (at a minimum, the Co-Chairs) will be included in discussions leading to decisions that affect HIV prevention in San Francisco, such as plans for supplemental funds, funding applications, and prevention-related DPH policies.

Disclosure - To the degree possible, information, especially information that leads to decisions, will be shared as broadly as possible.

Pro-Active - The AIDS Office and HPPC will communicate to each other about actions either intends to take, before decisions are finalized.

Responsive - If a change to a previous agreement or understanding is considered, this will be communicated to the other party early in the discussion.

Timely - A response to issues raised will be made within 5-10 working days.

Principles guiding communication between the HPPC and other advisory bodies and policy-making entities such as the Treatment on Demand Planning Council, the CARE Council, the Health Commission, etc.

The HPPC will strive to let other advisory bodies know about its work and priorities. Examples of ways to communicate include distributing copies of the Prevention Plan, presentations by Council members, joint meetings, joint members, time on the agendas, and distribution of agendas for upcoming meetings.

Principles guiding communication between the HPPC and members of the public and prevention provider community.

The HPPC will actively strive to include the knowledge and perspectives of communities in the development of its priorities and the Plan. Public comment is one vehicle for obtaining input from the greater community. Writing press releases, inviting members of the press to attend and report on meetings, writing articles and hosting discussions open to the public are additional examples. Council members are responsible for explaining HPPC recommendations to people in the community and for bringing back to the Council input from the community. As needed, the Council may convene panels or focus groups to further include community input. Upon request of the Council, the Process Evaluation Team can gather data and make recommendations on Council and public communications.

J MUTUAL ACCOUNTABILITY

The partnership between the HPPC and the AIDS Office depends on each person valuing her or his own role and the roles of others involved in the planning process. Each person involved should understand and appreciate what is expected of her or him and attempt to fulfill these expectations. In this way, we can each hold others to the same high standards of accountability we hold ourselves. The relationship between the HPPC and AO staff is a particularly important one — an unique in many ways — and therefore deserves more specific articulation of communication principles.

Responsibilities of HPPC Members.

1. The responsibility of HPPC members to the Council as a body is to:
   regularly attend meetings;
   constructively participate in Council activities, recommendations, and decisions;
   keep informed about activities related to the Council, the community and about HIV prevention issues;
   share vision and expertise;
   provide input on planning directions;
   listen to and respect other Council members;

support one another;
create and nourish partnerships and collaborations; and
support Council decisions.

2. The responsibility of HPPC members to their colleagues in the community is to:
keep them informed of HPPC activities, recommendations, and decisions;
solicit feedback and communicate that feedback to the HPPC; and
support Council decisions and recommendations in the community.

3. HPPC members' responsibilities to the community of affected and infected individuals is to:
be informed about HIV prevention issues and community needs;
keep the needs of the infected and affected in mind while establishing priorities and conducting community planning;
establish recommendations that are likely to have the greatest impact in stopping the epidemic;
seek and listen to community input;
be inclusive of community members in planning — provide a voice for affected and infected individuals at the Council and in committee meetings; and
welcome the input and participation of HIV-positive people.

4. HPPC members' responsibility to AIDS Office staff is to:
communicate through respectful engagement;
create and nourish partnerships and collaborations; and
communicate openly, honestly, and directly.

5. HPPC members' responsibility to themselves is to:
take care of themselves to prevent burnout;
take pride in the work;
acknowledge their abilities and limitations;
accept responsibility for their participation; and
be committed to the process of HIV Prevention Community Planning.

Responsibilities of DPH/AO Staff.

1. The responsibility of DPH/AO staff to the Council is to:
regularly attend meetings as appropriate;
keep informed about activities related to the Council, the community and about HIV prevention issues;
maintain regular communication with the CDC and State Office of AIDS;
share vision and expertise;
provide input on planning directions;
listen to and respect Council members;
communicate through respectful engagement;
communicate openly, honestly, and directly;
provide timely communications;
create and nourish partnerships and collaborations; and
support Council decisions.

2. The responsibility of DPH/AO staff to prevention providers in the community is to:
respond in a timely fashion through accessible venues;
meet published deadlines;
educate the bureaucracy about community issues;
keep providers informed of HPPC activities, recommendations, and decisions;
take leadership in policy interventions; and
support Council decisions and recommendations in the community.

3. The responsibility of DPH/AO to itself is to:
support DPH mandates and policies;
advocate to the DPH on behalf of the community planning process;
accurately represent HPPC concerns and matters in a timely fashion;
and inform and provide or arrange for training to other city departments and DPH divisions about the HPPC and HPPC's work.

4. The responsibility of DPH/AO staff to themselves is to:
take care of themselves to prevent burnout;
take pride in the work;
acknowledge their abilities and limitations;
accept responsibility for their participation; and
be committed to the process of HIV Prevention Community Planning.

K CONFLICT RESOLUTION

In any group endeavor, conflict is normal and expected. What defines a successful group effort from a failed effort is the ability to resolve conflict fairly and quickly. This section outlines procedures to address two types of conflict — concerns about recommendations developed within a committee, or other body of the Council, and concerns or issues that arise outside of the committee structure.

Procedures for addressing concerns about recommendations being developed by a committee, task force, or other special body of the HPPC.

1. A committee develops preliminary recommendations and prepares to present them to the Council for discussion and concept vote. If possible, a written copy of the recommendations is sent to HPPC members in advance of the meeting. Time is set on the agenda to discuss the committee recommendations. The committee chair or designee presents the recommendations, including how the recommendations relate to the Prevention Plan and how the recommendations may impact the community. The Council discusses the recommendations and members are encouraged to express their opinions. The Co-Chairs facilitate a concept vote. A concept vote indicates Council approval to go forward with the general direction of the recommendations, taking into account discussion and input that came from the Council at the meeting.

2. Between Council meetings, HPPC members who have concerns about the recommendations may want to attend relevant committee meetings call the committee chair to express concerns, or write a memo to the committee outlining their concern. Additionally, HPPC members may want to engage in one-on-one problem-solving discussions with other members of the HPPC.

3. The committee considers all input received by HPPC members and finalizes the recommendations. The recommendations are brought to the Council for final vote.

4. At a meeting of the full Council, the recommendations are presented and discussed. In most cases, a vote will be taken on the recommendations after discussion. However, if the discussion indicates that there are substantial concerns about the recommendations, more discussion may be needed than time permits. HPPC members will try to resolve the issues in one meeting. If necessary, the Council can negotiate for an additional 10 - 15 minutes to attempt resolution. If no resolution is possible in that time, it will be necessary to return to the agenda and continue the discussion at the following meeting. For especially difficult issues, it may be necessary to arrange for a special facilitator at the following meeting to resolve the issues.

5. It is hoped that recommendations can be passed by consensus; if consensus cannot be achieved, recommendations can be passed by a majority vote. If a minority of members are strongly against a recommendation that passed HPPC vote, they may write a letter voicing minority opinion to be incorporated into HPPC minutes. When appropriate procedures have been followed to make recommendations, all members are expected to support the recommendations as legitimate Council decisions.

Procedures for addressing concerns from the HPPC or an HPPC member which do not originate within a committee.

Most of the work of the HPPC is delegated to a committee for preliminary discussion, investigation, and formation of recommendations. There arise, however, issues which do not have their origin in a committee. The following procedures can be used to address concerns about these types of issues.

1. If HPPC members perceive an issue or conflict that needs resolution, they should first contact the Co-Chairs and ask for time on the next agenda to present the issue or conflict.

2. Before the Council meeting, they should gather information (including information from the community, information from the Prevention Plan, information that describes the problem). The group should present their concerns in relationship to the Prevention Plan and to the impact on the community. They are encouraged to present information in writing prior to the meeting, if possible.

3. The Council will engage in discussion after the presentation. HPPC members will try to resolve the issues in one meeting. If necessary, the Council can negotiate for an additional 10 - 15 minutes to attempt resolution. After that additional time has been used, it will be necessary to move forward with the agenda and continue the discussion at a following meeting.

4. During the meeting, the HPPC votes on whether to pursue this issue.

If the vote is NO, (don't pursue the issue) then the minority group should move forward with Council activities and may write a minority opinion for HPPC minutes. If members engage in activism about the issue outside of the HPPC, they may not use the Council's name or authority.

If the vote is YES, (pursue the issue) then:

5. Continue the discussion at the following meeting. For especially difficult issues, it may be necessary to arrange for a special facilitator to assist in resolving the issues. It may be necessary to invite someone to that meeting who can respond to the concerns. After discussing the issue with the appropriate person(s), the Council votes on whether to affirm the issue as a Council concern.

If the vote is NO, (not a Council concern), then the group should move forward with Council activities and may write a minority opinion for HPPC minutes. If members engage in activism about the issue outside of the HPPC they may not use the Council's name or authority.

If the vote is YES, (is a Council concern) then:

6. The Council clarifies the issues (lists specific points that need resolution) and invites the appropriate person(s) back to a special meeting or next HPPC meeting. It may be necessary to form an ad hoc group or task force to recommend solutions to the issue.

7. At that meeting (the third meeting on the topic), the HPPC and other entity (if there is one) problem-solve ways to resolve the issues. The HPPC then votes on whether these steps will resolve the issue.

If the vote is YES, then the steps are taken.
If the vote is NO, (steps will not resolve issue) then:

8. The Council votes on next steps to be taken — letter writing, further attempts at resolution, or carry out the grievance procedures (outlined in a separate section).

L GRIEVANCE PROCEDURES

Sense of partnership, respect, communication, mutual accountability, and methods for conflict resolution should enable the Council and AIDS Office to overcome difficulties in years to come. However, in the event that one or more of these breaks down and the Council perceives that its work has been violated, there must be an established recourse. This section outlines the recourse that the Council should take when attempts to communicate and resolve conflict have failed.

In the event of disagreements and/or differences which cannot be resolved through discussion between the HPPC, its Co-Chairs and the staff of the AIDS Office, grievances will be filed and arbitration will be sought to reach resolution on the matter. The procedures are outlined below:

1. Advise the CDC Program Officer about the intention to file a grievance with the Department of Public Health.

2. File a grievance with Director of Community Health, Promotion and Prevention.
The Director of Community Health, Promotion and Prevention (through dialog with the Director of Public Health) will formulate a response to the Council. If the response is acceptable to the majority of HPPC members, the matter is resolved.

3. If the majority agrees that the response does not resolve the grievance, a grievance is filed directly with the Director of Public Health. The Director of Public Health will formulate a response to the Council. If the response is acceptable to the majority of HPPC members, the matter is resolved.

4. If the majority agrees that the response does not resolve the grievance, the matter is taken to a professional mediation service. If the majority of members find that work with the mediation service resolved the grievance, the matter is resolved.

5. If the majority agrees that the mediation did not resolve the grievance, the matter is brought to the CDC Project Officer for a binding recommendation.

CHAPTER 2 - CULTURAL COMPETENCY

I. INTRODUCTION

Issues of cultural competency were a major focus of the HIV Prevention Planning Council (HPPC) during 1997. For many months Council members debated the many definitions of culture and the meaning of cultural competency. By the end of the year, the Council had developed 25 *Guiding Principles of Cultural Competency* and the *Cultural Competency Assessment Tool,* an instrument for assessing the cultural competency of HIV-prevention providers. With the next Request for Proposals (RFP) process, the AIDS Office will require HIV-prevention providers applying for funding to complete this instrument as one component of the Request for Proposals (RFP) process.

This chapter describes the processes and methods that were used to develop the *Cultural Competency Assessment Tool.* Equally importantly, it presents the *25 Guiding Principles of Cultural Competency* which summarize issues of cultural competency as they relate to effective HIV-prevention. The tool itself is included in this chapter, as are suggested next steps for its implementation.

Background

The HPPC believes that HIV-prevention is most effective when providers are culturally competent to serve their target populations. According to a report of the Multicultural Liaison Board of the California State Office of AIDS, "HIV education must be placed in the context of people's lives to be effective." (Multicultural Liaison Board, 1995) HIV, perhaps more than any other disease in modern times, is intertwined with stigma and political implications that complicate its meaning in people's lives. It cannot be viewed solely in biological terms. The report goes on to explain that cultural understandings of AIDS, disease, death, sexuality, family, health care, and government all affect individuals' perception of both HIV-prevention messages and the individuals and institutions delivering those messages. Education programs which fail to recognize the interplay of culture and disease prevention run the risk of alienating the people they are trying to serve. To effectively provide HIV prevention services — to be credible enough to inspire changes in risk-behaviors — providers must not only have "a *passive* understanding of the historical, cultural and linguistic issues," of the communities they serve, they must also "know how to *actively* apply this knowledge when interacting with members of the community." (Multicultural Liaison Board, 1995)

The HPPC has long recognized the importance of ensuring culturally competent prevention services. One of the Council's original goals from the first year of HIV prevention planning reads, *Prevention efforts shall be culturally appropriate.* The two objectives listed under this goal include developing a definition of cultural competency, and requiring providers to demonstrate cultural competency consistent with that definition.

Yet, despite recognition of the importance of cultural competency in HIV prevention, the HPPC has had difficulty in prioritizing work on this goal in past years. Some Council members, as well as others in San Francisco, were critical of funding decisions made during the 1996 implementation of the Plan. The funding allocation process, some felt, did not satisfactorily take into account the cultural competency of the agencies applying for funds. The Council decided that it needed to take action to ensure all of San Francisco's diverse communities were being served by providers who were not only skilled in HIV-prevention, but fluent in the cultures of the people they served.

Although the goal of ensuring culturally competent HIV prevention services was clear, how to accomplish it was not. No criteria on which to base the assessment of an agency's cultural competency existed. More fundamentally, there was no clear and commonly accepted understanding of what was meant by "cultural competency". In order to realize its goal of ensuring the provision of culturally appropriate prevention services to San Franciscans, the HPPC first had to determine what it meant by cultural competency and then develop mechanisms for assessing it. The Linkages Committee was created in 1997 to meet this challenge.

II. COMMITTEE OPERATIONS

Committee Membership

The Linkages Committee members all volunteered to serve based on their personal interest and/or expertise in issues of diversity and multiculturalism. The diversity of the nine member committee was a resource in and of itself, as members all brought differing perspectives to bear on the issues of cultural competency. The Committee, chaired by an African American woman, was comprised of four Latinos/as, one Native American, one Asian, and two Caucasians. Committee members represented a mix of sexual orientations, as well. In addition, a community representative and an AIDS Office staff person served on the Committee. Members were assisted by technical support, process evaluation, and logistical support consultants. The Committee met a total of 17 times between March and December of 1997.

Decision making by the Committee was largely conducted without formal votes. Most decisions were made through a combination of brainstorming sessions and long conversations. Toward the end of the year, as decisions were being finalized, the Committee adopted a more formal consensus requirement for decision making. Because of the politically sensitive nature of the task at hand, the Committee strived to include as many perspectives in its work as possible. Not only did Committee members draw from a wealth of previously produced materials on cultural competency, but they also interviewed community leaders, surveyed community-based organizations, and gathered input from the larger HPPC membership. These activities significantly influenced the final version of the Assessment Tool.

Committee Tasks

The Linkages Committee's work began with the assignment of three tasks. Those tasks were:

- Review definitions of organizational cultural competency developed by other groups;
- Develop a definition of organizational cultural competency; and
- Develop a checklist, questionnaire or other instrument that RFP review panelists can use when assessing proposals submitted to the AIDS Office.

Before beginning work on the Cultural Competency Assessment Tool, the Committee spent time laying a theoretical foundation for its work. As part of the task of identifying a definition of cultural competency, the Committee collected and discussed materials on issues of cultural competency from sources such as:

- The Gay Men of Color AIDS Summit
- The National Asian and Pacific Islander HIV Resource Center
- The Multicultural AIDS Resource Center of California
- The California Office of Multicultural Health
- US Public Health Services; the California Cultural Competency Task Force
- The Multicultural Liaison Board

(A bibliography of source materials can be found in Appendix 1 of this chapter. A summary of key points contained in these documents is located in Appendix 2.)

After reviewing these materials and selecting definitions of cultural competency, the Committee next began work on the *Guiding Principles of Cultural Competency*. Detailing specific elements of cultural competency, these principles go beyond simply defining the term. The Committee chose to develop these principles as a way to provide a context for their work. In many ways, the principles are at the heart of the Committee's work. It was during this phase of the process that Committee members wrestled with the many philosophical issues inherent in their work.

To assist in the development of these principles, the Committee requested the technical support consultant to conduct a series of key informant interviews to verify that their work was in alignment with views of the provider community. Eleven key informant interviews were conducted with San Franciscans knowledgeable about HIV prevention and issues of cultural competency. Informants were asked to define cultural competency generally, and suggest important indicators which could serve as evidence of the cultural competency of individual agencies. Findings from these interviews informed the final version of the principles as well as the actual Assessment Tool. (A summary of interview findings can be found in Appendix 3.)

Development of the *Cultural Competency Assessment Tool* followed directly from the *Guiding Principles of Cultural Competency*. The process began by adapting specific principles into open-ended questions designed to illicit information that would indicate whether or not the principle was adhered to. These questions were then reorganized and prioritized, and, in some

cases, combined or eliminated. The remaining questions were further fine-tuned into a form appropriate for a data collection instrument.

Once the tool was in a complete draft, the Committee solicited community input to ensure a valid instrument. It requested a survey of all HIV care and prevention service providers who have contracts with the San Francisco AIDS Office. Survey respondents were asked to answer questions regarding the clarity and validity of the Assessment Tool. Committee members incorporated the comments of community service providers as they completed the development of the tool. (A summary report of survey findings are in Appendix 4 of this chapter.)

As a final method for including multiple perspectives, the Committee tapped into the expertise and knowledge of other HPPC members. Before presenting the Assessment Tool for a final vote, the Linkages Committee made three update presentations to the full Council and engaged members in a substantive discussion on issues related to the Assessment Tool. These discussions with the full Council led to a number of improvements in the final version of the tool.

III. DEFINITIONS OF CULTURAL COMPETENCY

The Committee identified three definitions of cultural competency cited in *Operational Definition of Cultural Competence in a Public Health Department*, by the California Office of Multicultural Health.

USEFUL DEFINITIONS OF CULTURAL COMPETENCY

Cultural competency is a process that requires individuals and systems to develop and expand their ability to know about, be sensitive to, and have respect for cultural diversity. The result of this process should be an increased awareness, acceptance, valuing and utilization of and an openness to learn from general and health-related beliefs, practices, traditions, languages, religions, histories and current needs of individuals and the cultural groups to which they belong. Essential to cultural competency is appropriate and effective communication which requires the willingness to listen and learn from members of diverse cultures and provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of individuals' cultural health beliefs and practices.

Source: *Recommendations for the Medi-Cal Managed Care Program. Cultural Competency Task Force. UCB, 2/9/94*

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations.

Source: *Towards a Culturally Competent System of Care (Vol. 1): CASSP Technical Assistance Center, Georgetown Univ. Child Development Center, Washington, DC, March 1989.*

A **culturally competent provider** appreciates differences, is responsive to needs, and provides intuitive interventions.

Source: *How Do We Color Our Health Care? A Cultural Diversity Guide for Kaiser Permanente Health Professionals in the Los Angeles Service Area. Los Angeles Kaiser Permanente Medical Center. 1994.*

IV. GUIDING PRINCIPLES OF CULTURAL COMPETENCY

The *Guiding Principles* articulate the Council's understanding of cultural competency. Rather than viewing cultural competency as a single skill, the *25 Guiding Principles of Cultural Competency* address a set of skills, policies, behaviors, and attitudes which together embody a complex approach to cultural competency. The Committee recognized that settling on a single definition of cultural competency would be difficult. Moreover, once developed, the principles could serve to guide the remainder of the Committee's work. Moreover, by disentangling the many aspects of cultural competency into discrete principles, the *Guiding Principles* serve as a road map for agencies interested in evaluating and improving their own cultural competency.

While the principles speak for themselves, there are a few central themes which are helpful for understanding the Council's intent. To begin, the Council views culture broadly, including not only race and ethnicity, but factors such as socio-economic status, age, gender, and sexual orientation. Additionally, the Council believes culturally competent prevention providers will be sensitive to subcultures within a culture. Members of a **subculture** share many or most of the defining characteristics of the group of which they are a part, but are also defined by characteristics which differentiate them from other members of the group. For example, gay male Latinos are part of a larger community of Latinos, but, because of their sexual orientation, are also members of a subculture within the larger Latino culture.

Most importantly, the Council encourages providers to continually strive to understand and respect the cultures of their clients. At a minimum, this means maintaining an open dialogue with clients and working together to define needs. Rather than expecting clients to adjust to the culture of the agency, culturally competent providers will design interventions appropriate for the cultures of the groups they target.

Finally, the Council recognizes that achieving cultural competency is a complex process: every prevention provider falls somewhere along a continuum of cultural competency. Improving cultural competency is an ongoing process, achievable by the adoption of certain policies and procedures suggested by the principles.

The following 25 *Guiding Principles of Cultural Competency* are divided into two categories: Broad philosophical statements are found under the heading *Overarching Principles*; those statements which are more relevant to an agency's policies and procedures are under the heading *Agency-specific Principles.*

25 Principles of Cultural Competency
Developed by the Linkages Committee of the
San Francisco HIV Prevention Planning Council, 1997

Overarching Principles

1. Define culture broadly, encompassing an individual's race, ethnicity, gender, sexual orientation, age, language, and other defining characteristics.
2. Recognize and respect that culture is ever-changing and evolving.
3. Recognize the diversity within and among multicultural communities.
4. Recognize the dynamic interaction between culture and health.
5. Recognize the distinction between cultural identification and class.
6. Recognize and be sensitive to the diverse languages and dialects used by different communities.
7. Treat all San Francisco residents with respect, exhibiting sensitivity for their cultural practices.
8. Develop and support programs that address the needs of the local populations shown to be at risk.
9. Support programs that strengthen the capacity of communities to promote their own health.
10. Ensure that service providers are accountable for addressing the complexity of culture and subculture, including race, ethnicity, gender, sexual orientation, age, language, and other defining characteristics.
11. Question and challenge cultural stereotypes.

Agency-Specific Principles

12. Make time for clients to advocate on their own behalf so that services can be developed to address clients' specific needs, as they have defined them.
13. Incorporate ongoing needs assessments with the target population into the organization's policies, resource allocation, program design and implementation practices.
14. Understand and address the needs of the various subcultures within the target population served by the agency.
15. Solicit, acknowledge and support clients' own definitions of who they are, refraining from categorizing them into pre-defined, inappropriate and/or restricting categories.
16. Strive to understand and respect the ever-changing nature of culture.
17. Recognize that organizational cultural competency requires a combination of appropriate staff representation and training in cultural competency to enable staff to understand and meet the needs of their target populations.

Continued on next page

Continued from previous page

18. Staff programs at all levels, paid and volunteer, with people who reflect the cultures of the populations they serve.

19. Train staff at all levels, paid and volunteer (including ASO Board members), about the cultures of the program's target population and how to approach meeting the needs of that population.

20. Nurture client/provider relationships that respond to and are sensitive to the client's culture.

21. Approach clients in a non-judgmental fashion, building trusting relationships.

22. Provide equal access to services and resources for all persons within a program's target population, including its various subcultures.

23. Create mechanisms to link individuals who present for services but are not in the program's target population to other providers who can address their needs.

24. Create an ongoing process to monitor the organization's level of cultural competence, including recognizing achievements and identifying and addressing shortcomings.

25. Evaluate the effectiveness of the program to improve the health status of the target population, and incorporate that feedback into revised program models and practices.

V. THE CULTURAL COMPETENCY ASSESSMENT TOOL

The purpose of this Assessment Tool is to look at a variety of measures that allow the AIDS Office to assess an agency's cultural competency as part of the funding allocation process. All agencies submitting an application in response to a Request for Proposal (RFP) will be required to complete this Assessment Tool. This Assessment Tool looks at a variety of *indications* of cultural competency. It does not provide a scientific "cultural competency score." Nor is it able to prove one agency is more culturally competent than another. It does provide HIV-prevention service providers the opportunity to describe some of the ways in which their agencies are culturally competent to serve their target populations.

Answers to individual questions are not as important as the complete set of responses to all questions. Rather than trying to find the "right" answer to each question, the Council suggests agencies focus on the questions which best demonstrate their cultural competency. The Assessment Tool will be considered as one component of an entire proposal.

CULTURAL COMPETENCY ASSESSMENT TOOL

1. HIV-Prevention Programs and Target Groups

List all HIV-prevention programs offered by your agency. Next to each program, list the target groups, (and the subcultures within that group) the program serves.

When defining subculture consider race, ethnicity, age, sexual orientation, geography, class, socio-economic status, risk behavior, and any other relevant factor(s).

List the program for which you are applying for funding on the first line.

Program Name	Target Group(s)/Subcultures
List program for which you are applying for funding above	

2. Cultural Background of Program Staff and Agency Management

List the cultures and/or subcultures (including but not limited to race and ethnicity) of your target groups (from question 1 above). Indicate the number of program staff, management, board and, if you choose, volunteers who identify as being from the same culture.

Individuals that identify with more than one group can be counted more than once.

Culture or Subculture	Number of Front Line Staff (staff with direct client contact)	Number of Management or Administrative Staff	Number of Board Members	Number of Volunteers *(Optional)*

3. Program Language Capacity

What languages are spoken *fluently* by your clients and staff?

Language Spoken by Clients	Percentage of Front Line Staff Who Are Fluent in the Language	Percentage of Management or Administrative Staff Who Are Fluent in the Language

4. Cultural Competency Training

How many trainings to increase staff's ability to work effectively with clients did individuals in your program attend last year? Include trainings that focused on specific cultures, as well as trainings that focused on general issues of cultural competency.

Please include in your response:

- The name of the training
- A brief description of the training
- The agency or consultant who provided the training (if training was provided by your own agency, indicate that as well)
- The trainers' qualifications
- Percentage of staff that attended
- Percentage of volunteers that attended (if any)
- Dates it was offered
- Whether or not it was required.

Describe any changes that were made in program design due to information learned in the cultural competency training.

Describe any changes that were made in policies and procedure due to information learned in the cultural competency training.

5. Outreach to Target Groups

What are the points of entry to your program, or where do target groups/subcultures learn about your program?
(Check all that apply, indicate the language(s) used)

☐ Newspapers →	*(Which)*	*(Language)*
☐ Billboard →	*(Where)*	*(Language)*
☐ Flyers/leaflets →	*(Distnbuted where)*	*(Language)*
☐ Radio commercial or PSA →	*(Station)*	*(Language)*
☐ TV commercial or PSA →	*(Station)*	*(Language)*
☐ Referral →	*(Type of referral)*	
☐ Internet		*(Language)*
☐ Walk-in		
☐ Street outreach		
☐ Other (specify) →		

6. Efforts to Understand Target Groups

Describe your efforts to collect information on the needs and concerns of your target groups (and the subcultures within those groups). Examples of efforts may include, client satisfaction surveys, focus groups, public meetings, a review of published literature, or a more formal community needs assessments.

Please list each activity you have used. Choose your most successful activity and describe it in detail. Include in your description:

a) The Purpose or goal:
b) Who participated (sample characteristics):
c) Number of those who participated (sample size):
d) Date most recently completed:
e) Number performed during the last 24 months:
f) Results:
g) How this information was integrated into your program or agency

For each, who was involved in gathering this information?

Board	Volunteers
Management	Clients
Front Line Staff	Outside consultants
Other Agencies	Community Members

For each, who saw the results?

Board	Volunteers
Management	Clients
Front Line Staff	Outside consultants
Other Agencies	Community Members

Please attach to your proposal any instrument used (for example, survey, focus group questions, etc.).

7. Special Needs of Target Groups

For each target group (and subcultures within that group) you serve, indicate if there are norms or values that can present barriers to HIV-prevention work.

Describe how your program addresses the barriers that you identify.

You may also want to describe the resources and strengths of the groups you serve and the means by which they overcome these barriers.

The following is a list of example of norms and values which may present barriers to HIV-prevention This list is not exhaustive.

Examples of Barriers

a) denial of impact or presence of HIV in community
b) homophobia
c) distrust of medical establishment
d) norms that result from history of racism and discrimination
e) taboo against discussion of sex
f) taboo against discussion of death and disease
g) drug seeking behavior
h) poverty
i) fatalistic world view/hopelessness
j) power inequalities
k) gender inequality
l) homelessness
m) certain religious beliefs
n) language
o) illiteracy
p) other(s)

_____

8. Community and Client Involvement

Are there ways, other than as consumers or clients, that community members are able to become involved in your program?

Please specify level of responsibility and roles/ tasks.

9. Evaluation

Has your agency conducted an organization-wide evaluation of its own cultural competency within the last 12 months?
Yes No

If yes, is this evaluation formal or informal
Formal Informal

Describe
- the methods used in conducting this evaluation
- the findings and lessons learned
- any achievements and challenges in this area over the last 12 months

If a report was completed, please attach that report to your proposal.

10. Other Cultural Competency Efforts and Activities

What efforts does your program take to ensure its cultural competency?

11. Appropriateness of This Tool for Your Program

How well do you feel this tool helped to assess your program's cultural competency? Please explain.

VI. SUGGESTED NEXT STEPS FOR THE IMPLEMENTATION OF THE CULTURAL COMPETENCY ASSESSMENT TOOL

Although the *Cultural Competency Assessment Tool* is in final form, there are three steps necessary for its successful implementation.

1. Before the Assessment Tool can be implemented, criteria need to be developed for reviewers when scoring proposals. Criteria should detail the types of responses which would indicate an agency is either cultural competent or values cultural competency and is working toward improvements in this area.

2. It is also important the Assessment Tool be pilot tested on a small scale before being required of all agencies applying for City funding. Any data collection tool should be pilot tested before being implemented to identify any unanticipated problems. This is particularly true for this Assessment Tool, as assessing cultural competency is a new area and the tool is experimental. The Assessment Tool will need to be refined as indicated by the pilot test.

3. As a final step in the implementation of the Assessment Tool, a protocol should be developed to be used by the AIDS Office during the monitoring process. There are limits to the amount of information about cultural competency that can be ascertained from a written assessment tool. Site visits and interviews can be used to augment the information collected from the Assessment Tool. As part of its routine monitoring of grantees, the AIDS Office conducts site visits and interviews with prevention providers. A portion of the monitoring process should be dedicated to looking at agencies' cultural competency. The protocol should be based on the Assessment Tool and the Guiding Principles of Cultural Competency.

Appendices to Chapter 2 - Cultural Competency

Appendix 1	Bibliography of Cultural Competency Related Materials
Appendix 2	Summary of Cultural Competency Related Materials
Appendix 3	Summary of Key Informant Interview Findings
Appendix 4	Summary of Findings from Providers Survey

Appendix 1

BIBLIOGRAPHY OF CULTURAL COMPETENCY SOURCE MATERIAL

National Asian and Pacific Islander HIV Resource Center (1997). *Cultural Competency Resources for Asian and Pacific Islander HIV Prevention Programs.*

The California Office of Multicultural Health (1996). *Operational Definitions of Cultural Competence in a Public Health Department.*

Multicultural AIDS Resource Center of California (1993-95). *The AWARE Model of Communicating Across Cultures.*

Multicultural Liaison Board (1995). *Frameworks for Change.* For (For) HIV California Planning Working Group/ California Office of AIDS.

National Task Force on AIDS Prevention & National Latina/o Lesbian and Gay Organization (1995). *Report on Standards as Set Forth at the Gay Men of Color AIDS Summit.*

Sandoval C, Multicultural AIDS Resource Center of California (1994). *Cultural Inventory.*

Appendix 2

SUMMARY OF BACKGROUND MATERIALS ON CULTURAL COMPETENCY

Prepared April 1997

CULTURAL COMPETENCY PRINCIPLES

(Adapted form Cross, et. al. *Towards a Culturally Competent System of Care*)

- Works towards equal access to services and resources for racial and ethnic populations regardless of language and culture.
- Incorporates cultural knowledge and strengths into policy and practice, thus recognizing the interaction of culture and health.
- Respects all Californians and exhibits sensitivity for their cultural practices.
- Recognizes the diversity within various racial and ethnic communities and distinguishes between cultural identification and the culture of poverty.
- Supports programs that strengthen the capacity of multicultural communities to promote health.
- Establishes policies and procedures to promote racial and ethnic community participation in the allocation of resources and the design and implementation of interventions developed to address their health needs.
- Evaluates the effectiveness of its programs in improving the health status of racial and ethnic populations.
- Celebrates diversity.
- Creates an ongoing process to monitor its level of cultural competence, including the recognition of achievements and the identification of unmet needs.

Source: *Operational Definition of Cultural Competence in a Public Health Department.* The California Office of Multicultural Health.

Examples of Culturally Competent Practices

- Collects and analyzes racial and ethnic-specific demographic data to better assess clientele and to identify underserved or underutilized groups, etc. in order to improve service delivery and outreach efforts.

- Conducts community assessments involving members of the community in the planning, implementation, and reporting of these assessments and its findings.

- Consults with organizations or individuals who represent racial and ethnic population groups in the planning, implementation, and evaluation of programs.

- Considers cultural factors, such as language, race, ethnicity, customs, family structure, and community dynamics in developing its policies and services.

- Provides all staff, including managers, with cultural competency training.

- Actively recruits and retains a work-force (paid and voluntary) and Board of Directors reflective of the population served.

- Includes in job descriptions and performance evaluations the requirement that employees have an understanding of, and sensitivity to, serving diverse populations.

- Establishes partnerships with multicultural health and human services organizations and agencies to enhance its referral base.

- Employs client assessment instruments and procedures that identify culture-based beliefs and practices that affect service delivery.

- Employs culturally appropriate patient satisfaction instruments and procedures.

Source: *Operational Definition of Cultural Competence in a Public Health Department.* The California Office of Multicultural Health.

Standards for Culturally Competent HIV Prevention Interventions for Asian and Pacific Islander Populations

1. Access at all points of contact
    - all written materials culturally and linguistically competent
    - access to phone reception/messages
    - welcoming office reception, office signs/environment, venue/location
    - appropriate scheduling of office hours/events; provide ancillary services (food, transportation, child care) or participation incentives
    - includes family/community in programs
    - has standards for use of interpreters
    - seeks and advocates for linguistically and culturally competent referral linkages

2. Staffing
    - hiring/retention/promotion; affirmative action/outreach; commitment to staff diversity and parity; integration of cultural competency across entire staff
    - ongoing staff training, development and skills-building to increase cultural competency
    - outreach, recruitment and integration of volunteers from target community
    - use of consultants/vendors from target community

3. Content/context of HIV prevention interventions
    - based on knowledge/research on demographics and epidemiology of target population
    - identifies and addresses cultural barriers, e.g., taboos about sexuality, drug use, disease, death, mental health, etc.
    - uses indirect/contextual/pragmatic messages
    - uses multiple communication methodologies (graphics, illustrations, radio, television, video, etc.)
    - considers both individual and community norms/interventions (emphasizes shared/communal responsibility)
    - doesn't confront/embarrass/compete
    - promotes/reinforces appropriate health-seeking behaviors
    - planning goes beyond units of service/cost effectiveness

4. Decision-making
    - is agency client-centered?
    - management/supervisory staff and board representation from target community
    - participation of target community in planning, developing, implementing and evaluation of program in formal organizational structures
    - financial commitment to program development/expansion

5. Ongoing evaluation
    - commitment to institutional change to increase cultural competency: included in agency's strategic or long-range plan
    - process to monitor/measure progress in increasing cultural competency
    - long-term commitment to target community: participation and sponsorship of community events/promotion of community culture/art/history
    - supports community partnerships: defers to community leadership and supports funding of organizations based in target community

6. Actual access by target population/clients/consumers
    - measure change in access/intake data
    - monitor utilization/retention data
    - actively measure client satisfaction
    - measure client outcomes: increased knowledge, risk reduction, changed community norms
    - agency has appropriate complaint and grievance procedures

Source: *Cultural Competency Resources for Asian and Pacific Islander HIV Prevention Programs.* January 1997. National Asian and Pacific Islander HIV Resource Center.

The AWARE Model

Communicating Across Cultures

A Accept the other person's behavior without judging it based on what that behavior means in your culture.

W Wonder what the other person's behavior means in their culture rather than what it means in your culture.

A Ask what it means to them.

R Research and read about the other person's culture so that you are able to place their behavior in the context of their cultural world-view.

E Explain what their behavior means in your culture and demonstrate the behavior in your culture that expresses that feeling so that they can learn new behaviors that will help them function in your culture.

Source: Polaris Research and Development, Inc. 1993-95.

Standards of Cultural Competency Set Forth at the Gay Men of Color AIDS Summit

- HIV prevention strategies developed must be cognizant of and address cultural norms and social structures pertinent to diverse Gay Men of Color communities (e.g., geographic isolation, poverty, immigration status, societal mistrust).

- HIV prevention strategies developed must utilize the language and communication styles of the targeted Gay Men of Color community (e.g., regional dialects, literacy levels, hearing impaired, non-sighted, etc.)

- HIV prevention strategies developed must be cognizant of and respond to the diversity (e.g., nationality, language, tribe) within the various ethnic and multi-racial groups.

- HIV prevention strategies developed must consider the complexity of gender and sexual identity.

Source: *Report on Standards as Set Forth at the* Gay Men of Color AIDS Summit, August 31-September 3, 1995.

Cultural Competency

- Understanding the history of a particular community and its relationship to similar communities state-wide and nation-wide.

- Understanding the history and current situation of a particular community in relation to mainstream culture.

- Understanding the oppressions faced by the community, and the community's methods for resisting this oppression on personal, familial, and community-wide levels.

- Understanding specific issues of gender, ethnicity, and sexual orientation within the community.

Source: *Frameworks for Change*. Multicultural Liaison Board. July 1995.

Conceptual Definition of Cultural Competency

An organization's ability to honor, respect, and utilize in solving human problems, the beliefs, interpersonal styles, attitudes and behaviors both of families who are clients and the multicultural staff who are providing services. In so doing, the program incorporates these values into its policies, administration, and practices.

> **Source:** *Operational Definition of Cultural Competence in a Public Health Department.* The California Office of Multicultural Health

Defining What Culture Is

Culture is the blueprint of beliefs, behaviors, and identities which shape the perceptions of a person or a group of persons. It is an inheritance of ideas, practices, and attitudes which are conveyed and reinforced from generation to generation through institutions of society, like family, church, and community. Culture defines right and wrong, delineates assumptions and expectations, and ultimately describes our dreams and the meaning of life.

Culture is humankind's changing response to his/her environment, his/her interior search for connection to creation, and his/her need to act, react, and interact with members of the same species.

> **Source:** Chris Sandoval, Polaris Research and Development. 1994.

Definition of Cultural Competency

CULTURE: one's world-view, values, beliefs, customs and behaviors influenced by one's race, ethnicity, national origin, language, religious beliefs/spirituality, class/socioeconomic status, gender, sexual orientation, etc.

COMPETENCY: a required level of knowledge, skills and experience.

CULTURAL COMPETENCY: sufficient knowledge, skills and experience to communicate effectively with and work together with someone from a particular culture.

> **Source:** *Cultural Competency Resources for Asian and Pacific Islander HIV Prevention Programs.* January 1997. National Asian and Pacific Islander HIV Resource Center.

CULTURAL COMPETENCE: A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports the basic principals of cultural competency.

> **Source:** *Cultural Competence for Evaluators: A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities.* United States Public Health Services — Alcohol, Drug Abuse, and Mental Health Administration. DHHS Publication 92-60067.

CULTURAL COMPETENCY is a process that requires individuals and systems to develop and expand their ability to know about, be sensitive to, and have respect for cultural diversity. The result of this process should be an increased awareness, acceptance, valuing and utilization of and an openness to learn from general and health-related beliefs, practices, traditions, languages, religions, histories and current needs of individuals and the cultural groups to which they belong. Essential to cultural competency is appropriate and effective communication which requires the willingness to listen and learn from members of diverse cultures and the provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of individuals' cultural health beliefs and practices.

> **Source:** *Recommendations for the Medi-Cal Managed Care Program.* California Cultural Competency Task Force. University of California, Berkeley. February 8, 1994.

CULTURAL COMPETENCE is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations.

> **Source:** *Towards a Culturally Competent System of Care (Volume 1): A monograph on effective services for* minority *children* who *are severely emotionally disturbed.* CASSP Technical Assistance Center, Georgetown University Child Development Center. Washington, DC. March 1989.

A **CULTURALLY COMPETENT PROVIDER** appreciates differences, is responsive to needs, and provides intuitive interventions.

> **Source:** *How do We Color Our Health Care?: A cultural diversity guide for Kaiser Permanente Health Professionals in the Los Angeles Service Area.* Los Angeles Kaiser Permanente Medical Center. 1994.

CULTURAL COMPETENCE is a set of knowledge-based and interpersonal skills that allows providers to understand, appreciate, and work with individuals of cultures other than their own.

> **Source:** *Culturally Competent Health Care for Adolescents: A guide for primary care providers.* American Medical Association. 1994.

CULTURAL COMPETENCY is the ability of organizations and individuals to work effectively in cross-cultural or multicultural interactions. It refers to an organization's ability to recognize and use health attitudes, beliefs, behaviors, and communications patterns of its clients, their families, and its own diverse staff, to improve services, strengthen programs, increase community capacity, and close the gaps in health status among diverse population groups. In so doing, the organization reflects these values in its policies, practices, and programs.

> **Source:** CDHS/OMH, 1996.

Appendix 3

REPORT ON FINDINGS FROM KEY INFORMANT INTERVIEWS REGARDING THE ASSESSMENT OF CULTURAL COMPETENCY

Prepared July, 1997

This memorandum presents findings from a series of key informant interviews conducted on behalf of the HPPC Linkages Committee to explore perceptions of service providers about culture, cultural competency, and how to assess organizational cultural competency. This summary is intended to be used by members of the Linkages Committee as they develop a tool to assess cultural competency to be used in an RFP review process. As such, it should be viewed as a working document designed to assist this specific process.

Following a brief discussion of the purpose and methodology of the interviews, this memorandum discusses the findings in terms of four key issues: culture, cultural competency, indicators of organizational cultural competency, and barriers to assessing cultural competency. To the extent possible, this document provides references to areas where respondent answers were either in alignment with or differed from the discussions within the Committee.

PURPOSE

These interviews were conduced at the suggestion of members of the HPPC Linkages Committee for several reasons. On a broad level, the interviews were conducted to assess the extent to which the Committee's work in developing principles of cultural competency were in alignment with views in the community about this issue. Are the committee's ideas and views shared with others in the HIV prevention community, or not? The interviews also sought to draw upon the thinking that has already been done within the community about organizational cultural competency—what it is; how to assess it; the barriers to assessing it—to incorporate into the Committee's further deliberations.

METHODOLOGY

A total of eleven interviews were conducted with key informants who are knowledgeable about HIV prevention and issues of cultural competency across the City. Respondents represented a variety of different "cultures" in terms of their own identity and the cultures served by their agencies. The interviews lasted approximately 30 minutes, and all but one were conducted by telephone. Both the list of potential interviewees and the interview protocol were developed with substantial input from members of the Linkages Committee.

Readers should be cautioned about the limited generalizability of these findings. Because only a very small number of respondents were interviewed and non-random recruitment techniques were employed, these respondents do not represent a probability sample. Therefore these data should be regarded as more suggestive than definitive in nature.

CULTURE

Respondents were asked to describe the cultures served by their agencies and the characteristics of those cultures, with the underlying goal of ascertaining both individual and organizational definitions of culture. For the most part, these answers were compatible with the discussions within the Linkages Committee about cultures and were along the lines of this respondent who said that, "Culture is a complex array of shared values, norms, traditions, behaviors and experiences in the world that are valued in a creative way." Culture was viewed as a multi-faceted system comprised of a variety of dimensions, including some elements that a person is born with and others that change throughout one's life. Respondents identified a variety of components of culture, including race/ethnicity, gender, sexual orientation, substance-use, socio-economic status, language, HIV status, etc.

In this view of culture as a complex system, respondents felt that individuals may identify more with one aspect of their culture at one time, and another aspect of their culture at another time. A few respondents noted that there are certain cultures that tend to dominate an individual's identity, in particular the drug-using culture and street culture.

For the most part, service providers felt that their programs target certain cultures—usually more than one particular culture, but certainly not all cultures. There was a consensus that any population is comprised of various subcultures, and programs are targeted to, and subsequently reach, one or more of those subcultures. Providers must therefore understand which sub-cultures they do and do not serve, with an eye on whether they intend to serve any of the subcultures that they are not reaching, and if so, how they will reach that underserved population.

It should be noted that a few respondents first responded to the question of culture by discussing race/ethnicity, even though their further elaborations on the issue included a wider variety of dimensions of culture. This is an important issue for the Committee to consider, in that the term "culture" may be understood by some individuals and organizations to be equated with "race/ethnicity." It will be important for the Committee to ensure that providers understand the Committee's broad view of culture, in order for the Committee's work on cultural competency to be clear.

Within the discussion of culture, respondents working for agencies defined as serving multiple communities were also asked to explain their understanding of "multicultural." Following their explanations that any culture includes a variety of subcultures, they felt

that all cultures are in some sense multicultural. Yet multicultural, they felt, does not imply being able to serve everyone; rather, it implies serving a variety of cultures. One respondent felt that multicultural means trying to respond to the many sub-cultures in a population, and another said that it means embracing the diversity of their clients. Yet another felt that for a truly multicultural program, there are no limits to who can be served.

Cultural Competency

Cultural competency, as expressed in these interviews, involves recognizing, understanding and being sensitive to people's own definitions of their culture, including the norms and values that are important to them and which guide the way in which they live. For most respondents, cultural competency in a prevention setting necessitates a client-centered model of care where clients define themselves and their needs, and providers aim to meet those needs in a non-judgmental fashion. Communication was identified as a key tool to ensuring cultural competency.

One way identified to ensure cultural competency would be for providers to share all of the same cultural aspects and experiences as their clients. This would never be completely possible, however, because the very nature of being a provider sets someone apart from a client. Yet a majority of respondents felt that having providers as representative of the target population as possible is one method for ensuring cultural competency.

This was not, however, seen as the only way to ensure cultural competency. The majority of respondents felt that cultural competency can be learned. While it may be helpful for a provider to share some of the cultural aspects with their clients, this is not a requirement if the provider can develop other mechanisms to understand and respond to their clients concerns and needs. A few respondents went so far as to say that a provider with a very different cultural background from his/her clients may be able to provide more culturally competent services than a provider of the same cultural background, depending on their techniques for working with the clients. One respondent shared a model he had learned for developing cultural competency which involves passing through four stages: 1) unconscious incompetence; 2) conscious incompetence; 3) conscious competence; and 4) unconscious competence.

Indicators of Organizational Cultural Competency

Respondents identified a wide variety of indicators of organizational cultural competency. There was overwhelming agreement that cultural competency is a complex issue which manifests in a variety of ways within organizations, and that an examination of no one indicator would be sufficient to assess cultural competency.

What follows is a list of the cultural competency indicators identified by respondents, divided into the general categories of program outcomes, program design and evaluation,

program implementation, organizational and management issues, and staffing issues. Each indicator includes the approximate number of respondents (out of a total of 11) who mentioned this indicator. Please note that this is an approximation due to the fact that the Committee had not discussed specific indicators of cultural competency when these interviews were conducted, only guiding principles of cultural competency. In addition, these counts are based only on the indicators mentioned by respondents ***without prompting***.

Program Outcomes

Indicator	Number of Respondents
Is the program providing the services intended to its target population and achieving the desired outcomes? Note: For a few respondents, this was the most important indicator of cultural competency.	6

Program Design & Evaluation

Indicator	Number of Respondents
Does the program collect needs assessment data on a regular basis in order to understand the changing needs of the community?	7
Are client comments and criticism incorporated into program improvements?	3
Does the program's structure facilitate reaching all of the target population or only a segment of it?	2
To what extent is identifying and describing population subcultures included in program planning?	1
Is there a regularly scheduled program assessment process?	1
Does the program have a historical commitment to meeting the needs of its target audience?	1
Are new program models pre-tested with the community before full-scale implementation?	1

Program Implementation

Indicator	Number of Respondents
Are program materials provided in the languages and cultural contexts of the target populations?	6
Is the program client centered, meeting the needs of clients as defined by clients?	5
How comfortable are clients accessing the services offered?	3
How satisfied are clients with the services provided?	3
Are clients given program alternatives so that they can choose the intervention that best addresses their needs?	1
Does the program use a cultural assessment tool to determine the many facets of a client's culture?	1
Does the intervention reach beyond one socio-economic level?	1
Do services address the variations of a culture from one neighborhood to another?	1

Organizational & Management Issues

Indicator	Number of Respondents
Does the program build links to the community, such as through collaborations with other organizations?	5
Is cultural competency training provided for all levels of the organization: board of directors, senior management, middle management, line staff (both paid and volunteer)?	4
Are members of the board of directors culturally representative of the client population?	3
Does the agency have a plan to address cultural competency?	2
Are clients involved in making policies and protocols?	2
Does the agency's mission address the issues of culture and cultural competence?	1
Does the agency incorporate holidays celebrated by the target population into its activities?	1
Do internal records promote cultural competency by collecting data that is culturally relevant to the individual?	1
Are development activities directed toward diverse communities, including the target population?	1
Has the board adopted cultural competency policies?	1

Staffing Issues

Indicator	Number of Respondents
Does the program hire staff, at all levels, from the community being served?	7
Are staff who reflect the community being served actively included in organizational management and leadership?	2
Do staffing structures maximize the cultural and linguistic capabilities of the staff?	2
Do staff pay-scales encourage applicants who both identify with the target population and have the required skills?	1

Barriers to Assessing Cultural Competency

In general, the respondents interviewed said that assessing organizational cultural competency is a difficult and complex task. It is a subjective process that involves making assessments about an organization based on looking from the outside in, and attempting to evaluate the intelligence and self awareness of staff. They acknowledged that cultural competency is a sensitive issue, with many different views about what constitutes cultural competence when working with different populations. It involves balancing qualitative and quantitative data, and respondents believed that there will always be different opinions on how best to achieve that balance. About half of the respondents questioned whether it is even possible to assess cultural competency, although, for the most part, they commended the Committee for its efforts in this area.

Some of the pitfalls of assessing cultural competency mentioned in the interviews included the fact that providers already know the answers that assessors want to hear, as well as the limitations of the data, assumed to be primarily self-reported data, that would be used in the process. The question was raised of how to determine whether information provided is accurate or not. Lack of resources was also identified as a barrier to assessing cultural competency, with many programs lacking the capacity or resources to do community needs assessments and program evaluations to determine, and then attempt to improve upon, their cultural competency.

Another barrier mentioned involves the very nature of some programs and their target population. For some individuals, HIV prevention is not as high a priority as other issues in their lives, such as shelter, immigration, feeding their family, etc. No matter how good the intervention may be, these individuals will always remain very hard to reach. A program, therefore, may not necessarily lack cultural competence if it has difficulties reaching these people with prevention messages.

Two respondents noted that the difficulty with this process is that the people who want to assess organizational cultural competency are really interested in something else. They

are interested in achieving social justice—how to give disenfranchised populations more power and resources—not cultural competency. Assessing cultural competence, while perhaps interesting, will not answer or solve their questions and concerns.

In discussing barriers to assessing cultural competency, respondents also gave some suggestions for how to implement a proposal review process. In terms of the individuals chosen to review proposals, respondents urged that they clearly understand their role as universal advocates—advocating for the rights, privileges and well-being of the whole community, not just the communities to with which they personally identify. A few respondents also suggested that they should receive cultural competency training and be advised to be respectfully hesitant of the review process in all of its complexity.

In terms of enhancing the proposal process, several respondents suggested adding a site visit component in order to gather information that cannot be captured in a written proposal. They suggested interviewing all stakeholders in the agency, including members of the board of directors, management, staff, clients and other funders.

Respondents also mentioned the importance of developing cultural competency standards to ensure that all programs are evaluated with the same criteria. One respondent also suggested issuing a disclaimer, stating the limitations of the cultural competency assessment, while another stressed the importance of pilot testing any tool before it is made public.

Summary

Overall, these interviews confirm that the direction being pursued by the Linkages Committee follows the general thinking in the community about the meaning of cultural competency and the methods that can be employed to asses it. Respondents were generally supportive of the work being undertaken by the Committee, with the understanding that this is a complex, and at times arduous, task.

Appendix 4

EVALUATION OF DRAFT CULTURAL COMPETENCY ASSESSMENT TOOL SUMMARY OF SURVEY RESULTS

Prepared October, 1997

In order to receive community input and guidance into the process of developing a cultural competency assessment tool, the Linkages Committee of the HPPC developed a survey that was sent to 200 HIV/AIDS care and prevention providers. This survey included 11 draft questions from the Assessment Tool. Respondents evaluated each question in four areas—how well the question measures cultural competency; how easy the question would be to answer; how clear the purpose of the question is; and how good is the question overall. The response rate was very good. Forty-six surveys, or 23% of the 200 surveys distributed, were returned.

Survey Questions (asked of each Assessment Tool question)

A) Do you understand the purpose of this question?

B) How accurately would this question measure your agency's cultural competency?

C) Would this question be easy to accurately answer?

D) What is your overall impression of this question?

E) Do you have any comments on this question?

For question A through D, respondents rated the Assessment Tool question on a five point scale with 1 being a negative response and 5 being a positive response.

Generally, the comments made were constructive and thoughtful. Those who liked the instrument praised it for approaching the topic from multiple angles. While different people liked different questions, most found at least one or two questions they felt were valid measures of cultural competency.

Criticisms of the Assessment Tool fell into different areas. Commonly, respondents did not see the connection between cultural competency and a particular question. Many pointed out a good answer to a specific question—such as language ability—does not necessarily indicate cultural competency. There was a sense from some that the questions reduced the complicated issue of cultural competency to a series of simplistic measures. Finally, there were many complaints about the time and resources that would have to go into filling out this instrument.

The following table summarizes the survey findings. The remainder of this report briefly discusses important points made in open-ended responses.

Evaluation of Draft Cultural Competency Assessment Tool
Survey Results: Mean Average Scores of Individual Questions

Scale: 1 indicates a negative response, 5 indicates a positive response

	Question	Good Measure of Cultural Comp.	Good Question Overall	Easy to Answer	Clear
1	List target group and program	2.23	2.56	3.11	4.02
2	Sub/culture of staff, board, etc.	2.98	3.05+	3.28	4.38+
3	Language capacity	3.30+	3.51+	4.04+	4.63+
4	Cultural competency training	2.86	3.02+	3.70+	4.17+
5	Points of entry	2.77	3.11+	3.69+	4.18+
6	Degree clients determine services	2.00	1.93	2.32	2.85
7	Methods used to collect information on target groups	3.42+	3.43+	3.28	4.37+
8	Norms that are barriers	3.22+	3.35+	2.91	4.20+
9	Participation in events	2.78	3.07+	4.13+	4.22+
10	Ways to become involved	2.96	3.13+	3.82+	4.36+
11	Evaluation of cultural comp.	3.16+	3.05+	3.28	3.95
	Average Score	2.88	3.01	3.41	4.12

+ above average mean score

Question 1: List all HIV-prevention programs offered by your agency. Next to each program, list the target groups, (and the subcultures within that group) the program serves.

While some respondents agreed that the question was "a reasonable and valuable question to pose," many did not see the question's connection to cultural competency.

While many respondents indicated answering this question would be straight forward,. others felt that listing subculture, as the committee has defined it, is too complicated and would produce an unwieldy list.

Question 2: Indicate the cultural and/or subcultural (including but not limited to race and ethnicity) background of your program staff, management, board and, if you choose, volunteers.

One respondent summed up the most commonly expressed reservation about this question when s/he wrote, "This question only answers what ethnic/racial group staff are. It does not speak to their abilities to be culturally competent; only culturally representative." Others pointed out that, given the complexities of culture and subculture, a similar background does not necessarily make someone culturally competent.

Identifying the subcultures of staff, board and volunteers presented a complicated issue. One respondent wrote, "staff experience these surveys to violate their privacy. They feel trivialized — like they are tokens — when we request they self-identify in order to comply with the county's need to know. . . ethnic/racial/sexual orientation composition." Large staffs and volunteer pools also present problems. "I think this question can be overwhelming to do for 120 employees, plus board and volunteers," said one respondent.

Question 3: What languages are spoken by your clients, staff, and board?

Several people suggested the question ask what languages are spoken fluently, rather than simply spoken at all. Some felt language ability of board members is irrelevant. As with other questions, some respondents felt that language ability, by itself, was a poor measure of cultural competency.

Question 4: How many cultural competency trainings did individuals in your agency attend last year?

While a number of respondents questioned whether providing a training makes an agency culturally competent, more respondents felt this was indeed a good measure. In the words of one person, it "certainly gives a sense of an agency's commitment to cultural competence."

As with Council members, respondents raised the issue of evaluating the quality of the training itself. Some suggested the Committee ask for a count of the number of people participating, rather than the number of trainings offered. Council members suggested asking for the credentials of the trainers. One respondent believes this question is not relevant for ethnic-specific agencies. "If board and staff are reflective of the target population, and share values, norms, tradition, behaviors and experiences with clients, what cultural competency training would you recommend?"

Question 5: What are the points of entry, or where do target groups/subcultures learn about your program?

A number of respondents strongly stated this question measures an "ability to advertise, with no correlation to the ability to deliver services." Others, however, recognized the purpose of this question, saying, "this question gives clues to the agency's understanding of the cultures it is trying to reach." One respondent expressed concern that agencies do not always collect this information and would not know how a client heard about the program.

Question 6: To what degree are clients able to determine which services they receive?

Most respondents did not understand this question. Because of the question's vagueness, respondents felt it would be impossible to answer.

Question 7: Describe the methods you use to collect information on the needs and concerns of your target groups (and the subcultures within those groups).

One person was concerned that the Tool only asks about "needs and concerns" of target groups, and not also about "resources and strengths." This respondent believes that a culturally competent agency will see a community as more than simply a set of problems needing to be solved.

This question is not an easy one, as respondents clearly argued. "This type of information is extremely time consuming to gather," said one.

Question 8: Within each target group (and subcultures within that group) that you serve, indicate if there are norms or values that can present barriers to HIV prevention work.

Several respondents commented that this question substantively measured agencies' understanding of their clients. It was pointed out again that this question only focuses on needs and not on resources. One individual suggested the question ask the agency to describe how the barriers affect the group as well as how the agency responds to it. The respondent with the most negative comments wrote, "who is qualified to make this assessment? It is totally off-purpose to funded services. It turns the agency into a data collection program and adds nothing to the prevention or treatment of AIDS."

Question 9: List any street fairs, parades, or other public celebration or event at which your agency participated in the last 12 months. Which community, if any in particular, sponsored the event. Is that a community that you target?

Many respondents did not feel this was a good measure of cultural competency. "It means little or nothing," said one. "Anyone can pay for a booth at a fair," said another. A slightly more positive comment was, "attendance at least shows intent and interest, but not cultural competency." One person pointed out smaller agencies with smaller staffs and budgets, will not be able to participate as frequently as larger agencies, making this question somewhat unfair.

Question 10: Are there ways, other than as consumers or clients, that community members are able to become involved in your agency? Please specify level of responsibility and roles/tasks.

Some respondents did not feel this was a pertinent question, asking "what does this question measure?" Others respondents indicated they felt this was indeed a valid measure. "If folks aren't involved," wrote one individual, "then one would be able to question [the agency's] cultural competency."

Another respondent had a different point of view. This person pointed out "the whole concept of volunteerism is different from culture to culture." For example, poor people do not have the time to "get involved."

Question 11: What process does your agency use to evaluate its cultural competency? Describe any achievements in this area made over the last 12 months.

While many regarded this as a good measure of cultural competency, it was pointed out evaluations of cultural competency are not typically done. Many expressed strong resentment to yet another long and difficult question. One respondent asked, "What is the purpose of funding—to collect data or provide HIV services?"

CHAPTER 3 - THE SAN FRANCISCO PRIORITY-SETTING MODEL, REVISED

I. INTRODUCTION

In its first two years of operation, the San Francisco HIV Prevention Planning Council (HPPC) developed a priority-setting model and in the third year developed recommendations that guided the allocation of resources. In that third year, 1996, the AIDS Office implemented these recommendations, with some modifications, by issuing Requests for Proposals (RFPs) for three-year contracts for prevention services. Subsequently, some members of the Council and community expressed concerns about the ways in which the AIDS Office interpreted Council recommendations and about the priority-setting model itself. In 1997, the Assessment Committee formed to evaluate the RFP process (particularly the implementation of Council-approved recommendations), determine if the end results met the Council's prioritization, and revise the priority-setting model, if necessary.

This chapter first discusses the Assessment Committee's tasks and activities, then presents the recommendations and suggested follow-up tasks for the implementation of these recommendations. The Appendix to this chapter contains an initial draft of guidelines for resource allocation using the revised model. The chapter does not describe the previous (1996) priority-setting model or resource allocation recommendations: please see the 1997 San Francisco HIV Prevention Plan, Chapters 5 (Priority-Setting) and Chapter 6 (Resource Allocation) for a comprehensive presentation of these topics.

II. COMMITTEE OPERATIONS

Tasks of the Committee

Between March, 1997 and January, 1998 the Assessment Committee met 19 times to assess and revise the priority-setting model for San Francisco prevention services. Initial guidance for committee tasks was developed in 1996 by the HPPC Co-Chairs, based on discussion with members of the Resource Allocation Committee and other Council members. These tasks were:

Task 1: Review a preliminary resource inventory compiled by the AIDS Office and identify significant funding gaps in the context of priorities established in the 1997 Prevention Plan.
Task 2: Make recommendations to further refine the resource allocation process.
Task 3: Review and adjust the priority-setting model.
Task 4: Guide the format of the Resource Inventory.

As it turned out, only the last two of these tasks were taken up by the committee. At approximately the same time that the Assessment Committee began its work, an ad hoc Supplemental Funding Task Force was formed to make recommendations to the AIDS Office about the use of Supplemental Funds from the Centers for Disease Control and Prevention

(CDC). Through the process of identifying unmet needs, the Supplemental Funding Task Force reviewed a (fairly complete) draft of the resource inventory, and used it as one source to identify gaps and to develop recommendations for Supplemental Funding. Therefore, although the Assessment Committee did not officially complete Task 1, it was completed by an ad hoc task force.

As a part of its work to prioritize needs for supplemental funding, the Supplemental Funding Task Force made recommendations about an allocation process for Supplemental Funds, which the AIDS Office implemented. Additionally, another committee, the Assessment Committee, had several discussions about guidelines for resource allocation and drafted concepts that will be passed on to the next committee working on these issues (presented in Appendix A). Prior to the release of the next large RFP, further discussion and recommendations about the RFP process should occur.

The Committee's principal focus was on the assessment and revision of the priority-setting model (Task 3), which is described in this chapter. The committee also completed its task of guiding the format of the Resource Inventory (Task 4), presented in Chapter 4 of this Addendum to the Prevention Plan.

Committee Membership

When formed, 11 members comprised the Assessment Committee: six Council members (including the DPH Co-Chair and the former chair of the 1996 Resource Allocation Committee), one AIDS Office staff member, and four community members (including one of the 1996 Council Co-Chairs). During the year, two of the community members and two Council members left the committee, and a new Council member joined. In addition to these members, the committee received planning support from a logistical support contractor who took extensive minutes, a member of the process Evaluation Team who acted as a participant observer, an AIDS Office staff person as technical advisor, and a technical support contractor who provided general guidance to the committee and sought outside information and expertise on behalf of the Committee.

Activities of the Committee

The Committee operated according to a simplified version of Robert's Rules of Order, and decisions were made by majority vote. In its deliberations, the Committee sought out and used scientific opinion and lessons learned from the previous years' Councils. This extensive reliance on scientific and historic information is reflected in the steps taken by the Committee to review and revise the model. To form recommendations, members of the Committee took the following steps:

Reviewed the 1997 Priority-Setting Model Members received presentations from key individuals involved in the development of the original model including: the 1994/95 HPPC Co-Chairs of the Council that began development of the model; the 1995/96 Co-Chair of the

Council that completed the model; the 1996 Committee Chair of the committee that used the model for resource allocation; and the technical support provider who researched the model.

Assessed the necessity of revising the model Committee members discussed the strengths and weaknesses of the 1997 Priority-Setting Model during several meetings, and decided to keep some form of the matrix, and to find ways to bring the issues of co-factors and co-variates to the forefront of the model (rather than at the end in the proposal review criteria).

Determined a method for better incorporating co-factors/co-variates in the model The Committee invited epidemiologists and sociologists from UCSF's Center for AIDS Prevention Studies (CAPS) to discuss ways in which co-factors/co-variates could play a more central role in the model and to provide opinions about the use of population size, frequency of risk behavior, and prevalence in the matrix. Based on reactions to these guest presentations, the Committee decided that a small number of sub-populations at particularly high risk should be identified within each or across several of the Behavioral Risk Populations (BRPs). Sub-populations are defined by the co-factors and co-variates which combine to create particular high needs for HIV prevention services.

Sought information about how to simplify the matrix to improve its scientific validity The Committee asked the technical support consultant to interview behavioral scientists, mathematical modelers, and epidemiologists about the components that should be in the matrix, particularly how to use prevalence and incidence. After receiving a summary of the interviews, the Committee invited staff from the AIDS Office Seroepidemiology and Surveillance Branch and a researcher from CAPS to present and discuss their opinions about the use of prevalence and incidence in a priority-setting model.

Determined the components to be included in the matrix Based on information presented by the researchers, the committee voted to use incidence, and not prevalence, as the guiding element in the model. Specifically, the Committee decided to use a ratio of incidence percentage to total incidence (the percent of expected new cases of HIV for each BRP divided by the total number of expected new cases of HIV in the city). Additionally, the Committee decided that population size and prevalence should be listed in the matrix, but not used for prioritization.

III. RECOMMENDATIONS

After careful investigation of scientific information and thoughtful deliberation, the Assessment Committee presented to the full Council recommendations to revise the 1997 Priority-Setting Model. These recommendations were adopted by the Council in January 1998 and are listed below.

- The San Francisco HIV Prevention Planning Council recommends the prioritization of BRPs by incidence (number of estimated new HIV infections for each BRP divided by the total estimated number of new HIV infections in San Francisco in a 12 month period).

- The priority-setting matrix will also contain information about other relevant factors such as estimates of population size (for both HIV-positive and HIV-negative persons) and prevalence rates for each BRP.

- The HPPC recommends that in developing criteria for resource allocation, members should consider the size of each behavioral risk population, acknowledging that population size based on census information understates the size of many groups critical to the HIV epidemic such as undocumented residents and homeless persons.

- Prior to an RFP process, the Council will identify sub-populations within each BRP that should be ensured funding based on criteria developed by a future committee and approved by the Council. This recommendation is made to include co-factors/co-variates as a vital part of priority-setting.

The 1998 revised Priority-Setting model uses a two-pronged approach in establishing funding priorities: the first is the rank order of the Behavioral Risk Populations based on HIV incidence. The second is the identification of select sub-populations based on criteria approved by the Council. The Council's inclusion of sub-populations into the priority-setting matrix is a recognition that certain sub-populations are disproportionally impacted by HIV and/or require more effort to be reached effectively because of a high level of co-factors. The HPPC further recognizes that effects of co-factors and co-variates on HIV risk are difficult to explicitly quantify across BRPs and therefore to include (in numeric format) in the ranking. During the next phase of implementation, the Department of Public Health will solicit proposals that respond to HPPC priorities based on the rank order of Behavioral Risk Populations and, within this order, priorities based on the identified sub-populations.

Once the initial ranking has been completed and sub-populations have been identified, the HPPC will conduct one or more forums for community input through which community consumers and service providers have an opportunity to provide feedback on the priorities and provide useful information that may have been overlooked by the Council. This mechanism will enrich the priority-setting process by expanding the information base to include a range of perspectives and opinions among the diverse communities of San Francisco. This public input may be facilitated in a variety of ways, such as public testimony, "expert" panels with community response, or facilitated single-session work groups. A summary of the input from the community forum will be provided to the HPPC prior to final adoption of the priorities. The HPPC will review the committee recommendations and the summary of the public forum and then adopt (with revisions as necessary) priorities.

A sample (blank) matrix appears at the end of this chapter. This model will be used by a future committee to rank the Behavioral Risk Populations by their proportional incidence and to list specific sub-populations. Also at the end of this chapter is a table with information about size, prevalence and incidence based on the 1997 HIV Prevalence Consensus Meeting. (See Chapter 6 of this Addendum for more information about the Consensus Meeting.) Because data are not available for each BRP, some behavioral risk populations are clustered together in the HIV Prevalence Consensus Report. The Council hopes that before another implementation of

priorities through an RFP process, the AIDS Office will be able to provide estimates of size, prevalence, and incidence for each of the 12 behavioral risk populations.

The table below outlines key similarities and differences between the original and revised priority-setting model.

1997 Priority-Setting Model	1998 Revised Priority-Setting Model
• Uses BRPs	• Uses BRPs
• BRPs prioritized by: frequency of behaviors and relative risk of each behavior; prevalence; and populations size score	• BRPs prioritized by: incidence
• Sub-populations at especially high risk are not specified in the matrix	• Sub-populations at especially high risk will be identified for each of the BRPs in the matrix
• At least some funding to all BRPs	• At least some funding to all BRPs
• Minimum risk score calculated by provider	• No minimum risk score

IV. FOLLOW-UP TASKS

The Assessment Committee identified several tasks that logically follow from its work. Some of these tasks were initially considered by the committee, but time did not permit their completion; other tasks flow from the recommendations made by the committee. The Co-Chairs have been apprised of these follow-up tasks during their discussions of 1998 Council activities. These follow-up tasks are listed below.

- ***Develop criteria for identifying sub-populations that should be ensured funding*** Before the Council can identify sub-populations, evidence-based criteria must be adopted by the Council for identifying these high-need groups. Examples of such criteria include: disproportionate high risk for HIV; historically fewer services; barriers to developing adequate services.

- ***Develop resource allocation recommendations*** The committee considered recommending what specified percentage of funds should go to the highest-prioritized BRPs. (For example, 75% of funds to the top 3 groups, or 90% of funds to the top 8 groups.) Upon reflection, the committee decided that this task was best completed by a committee working closer in time to the release of an RFP.

- ***Develop guidelines for the technical review of proposals*** The committee began working on guidelines for the technical review of proposals. Several drafts were written and discussed. However, more time was needed to complete this task than was available.

- ***Consider the number of Behavioral Risk Populations*** In the first year of HIV prevention planning, the HPPC developed the paradigm of 12 behavioral risk populations. However, the committee suggests the need to re-consider this and increase or reduce the number, for example to reflect the role of persons who have sex with both sexes but identify as either straight or gay. A handout depicting several options was discussed by the Committee, but no recommendations were formed.

On the next page the revised Priority-Setting model is presented. Cells in the body of the matrix will be filled in, using the 1997 HIV Prevalence Consensus Meeting as a primary source. Sub-populations will be identified for the behavioral risk populations, as appropriate, by a future committee. Following this matrix is a table presenting information from the 1997 HIV Prevalence Consensus Meeting. (See also Chapter 6 of this Addendum.)

Priority-Setting Model, 1998

	Population Size Total	Pop Size HIV -	Pop Size HIV +	Prevalence No.	Prevalence Percent		Projected Incidence No.	Projected Incidence Percent
MSM-IDU: Sub-Populations:								
MSM/F-IDU Sub-Populations:								
MSF-IDU: Sub-Populations:								
FSF/M-IDU Sub-Populations:								
FSM-IDU Sub-Populations:								
FSF-IDU: Sub-Populations:								
MSM: Sub-Populations:								
MSM/F: Sub-Populations:								
MSF: Sub-Populations:								
FSM: Sub-Populations:								
FSF/M: Sub-Populations:								
FSF Sub-Populations::								
Adults, adolescents	**606,100**	**591,165**	**14,935**	**14,935**	100%		**499**	100%

6 BRPS USED BY THE CONSENSUS MEETING	Population Size Total	Pop Size HIV -	Pop Size HIV +	Prevalence No.	Prevalence Percent	Incidence No.	Incidence Percent
MSM-IDU, MSM/F-IDU	4,100	2,665	1,435	1,435	10%	53	**11%**
MSF-IDU	8,500	7,650	850	850	6%	76	**15%**
FSM-IDU, FSF/M-IDU, FSF-IDU	4,500	4,050	450	450	3%	41	**8%**
MSM, MSM/F	39,000	27,300	11,700	11,700	78%	283	**57%**
MSF	250,000	249,825	175	175	1%	15	**3%**
FSM, FSF/M, FSF	300,000	299,675	325	325	2%	31	**6%**
Adults, adolescents	**606,100**	**591,165**	**14,935**	**14,935**	100%	499	100%
Infants/children	105,000	104,935	65	65		1	
Total	711,100	696,100	15,000	15,000		500	

Appendix 1

SUGGESTIONS FOR RESOURCE ALLOCATION

This appendix contains Assessment Committee suggestions for resource allocation and proposal review. It must be noted that these have passed a concept vote by the Council, but not a final vote. **These suggestions will provide a springboard for the work of a future committee.**

HPPC'S GUIDANCE FOR PREVENTION FUNDING

The 1997 Assessment Committee developed draft concepts to guide Resource Allocation. While these were not finalized for presentation to the Council, it is hoped that they may be of use to a subsequent committee.

1) The Assessment Committee recommends that, at the outset of each funding cycle, the AO allocate funds specifically to promote HIV prevention for both HIV-positive and HIV-negative persons according to the documented needs of San Francisco in concordance with the Mayor's HIV Services Council and BRP priorities of the Council.
2) At least some funding should be allocated to each of the BRPs.
3) Generally, higher-ranked BRPs should receive more resources than lower-ranked BRPs.
4) Sub-populations identified by the HPPC in the priority-setting process should be ensured funding. The AIDS Office will develop the methods to ensure that funds are available for these populations. If, after conducting the RFP process, funding decisions based on the merits of proposals do not result in funding for the specified sub-populations, the AO may need to release a separate RFP or initiate sole source procurement actions, or use other mechanisms to assure that prevention services are available for these populations.

PRELIMINARY RECOMMENDATIONS FOR PROPOSAL REVIEW

1) When the AIDS Office develops a competitive request for proposals (RFP), at least two members of the Council not in conflict of interest will be invited to review the draft RFP and recommend to the AIDS Office changes to ensure that it is aligned with the priorities and recommendations of the Council. The AIDS Office will adopt these recommendations to the degree possible.

2) While it is the responsibility of the AIDS Office to conduct bidders conferences after the issuance of an RFP, the HPPC will collaborate with the AIDS Office in conducting trainings about and orientations to the Plan and its recommendations to enable applicants to write proposals responsive to the Prevention Plan and HPPC's recommendations.

3) The eligibility criteria (pre-screening criteria) for proposals should include the following:
   a. the proposal must address one or more of the BRPs;
   b. each proposal must be specifically directed to the HIV/AIDS epidemic in San Francisco;

c. applications must be submitted by specified deadline dates and times;
d. proposals must meet other eligibility criteria required by the funding source (for example, Federal, State, or City law or regulation).

4) The eligibility criteria should not remove from consideration proposals based on their technical merits. The technical review (conducted by a panel) will evaluate proposals on their technical merits.

5) Applicants should be informed in the RFP and at the bidders conferences that the technical review, conducted by a panel that includes both community representatives and AIDS Office staff, will focus on the quality of each proposal in relation to the proposal's responsiveness to the technical review criteria. The AIDS Office will then review proposals that pass the technical review to ensure that the priorities of the HPPC have been met:
    a) funding for prevention targeting both HIV-positive and HIV-negative persons will be allocated;
    b) all BRPs will receive some level of funding;
    c) higher-ranked BRPs will receive more resources; and
    d) the specifically-identified sub-populations will receive prevention funding. For most BRPs, it is anticipated that funding will be available not only for the specifically-identified sub-populations, but for other populations at risk identified by the applicant.

6) In addition to DPH-established criteria, the technical review will be based on the Priority-Setting and Strategies and Interventions chapters, including the following:
    a) Description of the most significant co-factors present in the target population;
    b) Proposed intervention(s) and reasons for selecting that intervention:
        1. How the intervention addresses the co-factors;
        2. How the intervention will result in behavior change;
        3. How the intervention meets the guidelines established in 1997 SF HIV Prevention Plan Chapter 4 - Strategies and Interventions, specifically:
        Required Standards for Service Provision;
        Expected Outcomes;
    c) Intention of the applicant to participate in the city-wide evaluation and collection of information about standardized variables ;
    d) Demonstration of coordination with other prevention and health care providers serving the same population and linkages of clients to other needed services ; and
    e) If a collaboration is proposed, applicants must describe the ways the projects will work together, using the essential elements of collaborations approved by the HPPC.

Chapter 4 - Resource Inventory of HIV Prevention Services

I. INTRODUCTION

The Resource Inventory is an overview of HIV Prevention Services funded during 1997 by the City and County of San Francisco Department of Public Health and directly through the Center for Disease Control (CDC). The inventory contains information for services funded through five different funding sources, all which operate under different funding cycles. These include:

- CDC funding (through the AO) for the Calendar year 1997;
- CDC Direct funding for the period from June 1997 to May 1998;
- CDC Supplemental funding (through the AO) for the period from December 1997 through December 1998;
- State of California funding (through the AO) for the period from July 1997 through June 1998; and
- City and County General Fund for the for the period from July 1997 through June 1998.

The resource inventory was developed by AIDS Office staff with information compiled from AIDS Office prevention contracts. The current format of the inventory is based on recommendations from the 1997 HIV Prevention Plan and was developed with guidance from the 1997 Assessment Committee. The completed inventory was presented to the Assessment Committee for review before final presentation to and adoption by the Council in January, 1998.

The resource inventory contains a key to abbreviations, and three exhibits which list HIV prevention services. These are organized by **Agency** (Exhibit 1), by **Intervention-Type** (Exhibit 2) , and by **Behavioral Risk Populations** (Exhibit 3). The chapter concludes with four brief exhibits showing aggregate funding by Behavioral Risk Population (Exhibit 4), by Race/Ethnicity (Exhibit 5), by Intervention Type (Exhibit 6), and funding for youth (Exhibit 7).

Limitations

Several limitations should be mentioned before any conclusions are drawn from the information in this chapter. These limitations include:

Cost of intervention For providers who are receiving CDC Direct funds and providing multiple interventions, it was not possible to calculate the cost of each intervention, since the funding is distributed directly through the CDC.

Co-variates and Co-factors The information about co-variates and co-factors that providers target is taken from the provider contracts with the AIDS Office. It is likely that providers target other co-factors and co-variates in addition to those listed in the tables.

A **co-factor** is an economic, social, behavioral, physical, or psychological factor that influences risk or makes a person more susceptible to getting the disease if exposed. Examples include poppers, STDs, poverty, self-esteem, depression, discrimination.

A **co-variate** is a demographic descriptor of a group useful in identifying them for services. Examples include ethnicity, age, and neighborhood.

Funding for Behavioral Risk Populations (BRPs) Ideally, the resource inventory should list the amount of funding for each Behavioral Risk Population; however, most prevention providers target more than one BRP with their interventions and did not specify the funding amount for each targeted BRP. In these instances, based on recommendations in the 1997 SF HIV Prevention Plan, the BRPs were clustered into groups as specified by the providers (*e.g.*, males who have sex with males; and males who have sex with males and females [BRP #3 and #4] or injection drug users [BRPs #1, #2, #5, #6, #7 & #8]). Combinations of BRPs that appear only once in contracts were placed in the "*other*" category (*e.g.*, the combination of "males who have sex with males; and females who have sex with males" appeared only once in contracts and is listed in "other").

It is important to note the following:

- In the lists that follow, funding amounts within an exhibit are not repeated. That is, funding amounts are not included in more than one category; and
- Agencies which target multiple BRPs may not serve the same number of clients from each BRP.

Race/Ethnicity The figures used to estimate the amounts of funding for race and ethnicity categories are based on the race and ethnic breakdown of clients served by each provider during the calendar year 1996 or the fiscal year 1996/97. These percentages are not based on race and ethnicity of clients currently being served by providers. A small difference in the race and ethnicity of clients currently being served may exist; however, it is unlikely that these figures are significantly different from the previous year.

Funding for youth It was difficult in some cases to determine exact funding amounts for youth (under 24 years old). With providers serving only youth it was possible to determine funding amounts; however, many providers target individuals who are 18 years and older. In these cases, it was not possible to determine what percentage of funding was reaching individuals under 24 years old. It is therefore highly likely that the amount of funding for youth is understated in these tables.

II. RESOURCE INVENTORY

Abbreviations are used extensively in the exhibits presenting HIV prevention services by agency (Exhibit 1), intervention type (Exhibit 2), and Behavioral Risk Population (Exhibit 3). This exhibit is the key to the abbreviations for agencies, Behavioral Risk Populations, and funding cycles.

KEY A: ABBREVIATIONS FOR BEHAVIORAL RISK POPULATIONS (BRP)

Abbreviation	Behavioral Risk Population
BRP #1, MSM-IDU	Males, transgender male to female (pre-op), female to male (post-op) who have sex with males and inject drugs
BRP #2, MSM/F-IDU	Males, transgender male to female (pre-op), female to male (post-op) who have sex with males and females and inject drugs
BRP #3, MSM	Males, transgender male to female (pre-op), female to male (post-op) who have sex with males
BRP #4, MSM/F	Males, transgender male to female (pre-op), female to male (post-op) who have sex with males and females
BRP #5, FSM-IDU	Females, transgender male to female (post-op), female to male (pre-op) who have sex with males and inject drugs
BRP #6, MSF-IDU	Males, transgender male to female (pre-op), female to male (post-op) who have sex with females and inject drugs
BRP #7, FSF/M-IDU	Females, transgender male to female (post-op), female to male (pre-op) who have sex with males and females and inject drugs
BRP #8, FSF-IDU	Females, transgender male to female (post-op), female to male (pre-op) who have sex with females and inject drugs
BRP #9, FSF/M	Females, transgender male to female (post-op) female to male (pre-op) who have sex with males and females
BRP #10, FSM	Females, transgender male to female (post-op), female to male (pre-op) who have sex with males
BRP #11, MSF	Males, transgender male to female (pre-op), female to male (post-op) who have sex with females
BRP #12, FSF	Females, transgender male to female (post-op), female to male (pre-op) who have sex with females

KEY B: ABBREVIATIONS FOR AGENCIES

Abbreviation	Agency	Abbreviation	Agency
APIWC	Asian Pacific Islander Wellness Center	**Larkin Street**	Larkin Street Youth Center
BCA	Black Coalition on AIDS	**LYRIC**	Lavender Youth Recreation and Information Center
CAITC	California AIDS Intervention Training Center	**RAP**	Real Alternatives Program
Central City Hosp	Central City Hospitality House	**SFDPH**	San Francisco Department of Public Health
FAP	Forensic AIDS Project	**SFGH**	San Francisco General Hospital
FTFA	Filipino Task Force on AIDS	**SEACC**	Southeast Asian Community Center
HAFCI	Haight Ashbury Free Medical Clinic	**SPY**	Special Programs for Youth
HAYOT	Haight Ashbury Youth Outreach Team	**TARC**	Tenderloin AIDS Resource Center
HPP	HIV Prevention Project	**UCSF**	University of California San Francisco
ICHO	Institute for Community Health Outreach	**WNC**	Women's Needs Center
IFR	Instituto Familiar de la Raza	**YUTHE**	Youth United Through Health Education

KEY C: ABBREVIATIONS FOR INTERVENTIONS

Abbreviation	Intervention
Cond. Dist	Condom Distribution
CTRPN	Counseling, Testing, Referral and Partner Notification
Hotline	Telephone Hotline
IRRC	Individual Risk Reduction Counseling
MSG	Multiple Session Groups
NE	Needle Exchange
PCM	Prevention Case Management
SSG	Single Session Groups
VBGO	Venue-based Group Outreach
VBIO	Venue-based Individual Outreach

KEY D: ABBREVIATIONS FOR FUNDING SOURCES AND CYCLES

Abbreviation	Funding Source/Cycle
CDC	Centers for Disease Control (January 1, 1997- December 31, 1997)
CDCd	Centers for Disease Control Direct Funding (June 1, 1997- May 30, 1998)
CDCsup	Centers for Disease Control Supplemental Funding (December 1, 1997- December 31, 1998)
State	State Office of AIDS Funding (July 1, 1997- June 30, 1998)
General	City / County of San Francisco General Fund (July 1, 1997- June 30, 1998)

EXHIBIT 1 FUNDING BY AGENCY

The following tables list currently funded services by agency. Information in these tables includes:

Agency - Name of Agency

Funding Source - This section lists the source of funds for each program (see Key D)

Amount of contract - This section lists the total contract amount of each agency.

Intervention type - The intervention type is based on the Strategies and Interventions Chapter in the 1997 San Francisco HIV Prevention Plan. In addition to interventions included in the plan, training services for providers, condom distribution, and evaluation were also included.

Cost of Intervention - This section lists the amount of funding each agency receives to implement an intervention. For agencies who receive CDC Direct funding to provide multiple interventions, it was not possible to calculate the cost of each intervention.

Behavioral risk population (BRP) - BRPs are based on the twelve behavioral risk populations prioritized in the Priority Setting Chapter of the 1997 Plan. Although agencies may target multiple BRPs, it should not be assumed that they are serving equal numbers of clients from each BRP.

Co-variates and Co-factors - Co-variates are race/ethnicity, age, and geographic location. Co-factors are biological or social factors that by themselves do not increase one's risk for HIV, but might influence behavior that increases the risk for HIV (*e.g.*, poverty, homelessness, STDs). Both co-variates and co-factors included in this exhibit were taken from program contracts. It is likely that providers target other co-factors and co-variates in addition to those listed in the tables.

EXHIBIT 1 FUNDING BY AGENCY

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
AIDS Health Project (UCSF)	State	$176,914	IRRC	$58,332			x										• 25 years and older
			MSG	$34,201			x										
			SSG	$40,640			x										
			EVAL	$43,742													
	State	$436,560	CTRPN	$436,560	x	x	x	x	x	x	x	x	x	x	x	x	
	CDC	$464,554	CTRPN	$383,374	x	x	x	x	x	x	x	x	x	x	x	x	
			EVAL	$81,163													
		$100,000	Training	$100,000													• Training for providers
API Wellness Center	CDC	$358,774	IRRC	$42,642	x		x	x									• Asian, Pacific Islander
			MSG	$166,938	x		x	x									• Transgender
			SSG	$13,606	x		x	x									• Monolingual
			VBIO	$80,037	x		x	x									• Immigrant
			EVAL	$46,760													
	General	$66,971	IRRC	$7,963	x		x	x									
			MSG	$31,161	x		x	x									
			SSG	$2,538	x		x	x									
			VBIO	$14,942	x		x	x									
			EVAL	$10,367													
	CDCsup	$25,000	IRRC-	$8,062	x	x			x	x	x						
			MSG-	$9,477			x	x									• Youth under 24 years
			VBGO	$3,080			x	x									
			Media	$4,381			x	x									

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
San Francisco Black Coalition on AIDS	State	$246,683	MSG	$37,003		x	x										• African American • Bayview-Hunter's Point, Castro, Potrero Hill and Double Rock neighborhoods
			SSG	$37,003		x	x		x								
			VBIO	$123,338		x	x		x								
			EVAL	$49,339													
	CDCsup	$20,000	IRRC-	$20,000	x	x			x	x	x	x					
Bureau of Family Health (SFDPH)	CDC	$182,701	CTRPN	$176,248	x	x	x	x	x	x	x	x	x	x	x	x	• Low income
			EVAL	$7,308													
CAITC/ ICHO	CDC	$145,173	IRRC	$76,416					x		x						• African American • Latina • Native American
			MSG	$43,917					x		x						
			SSG	$14,563					x		x						
			EVAL	$10,282													
CAL PEP	CDC	$228,138	SSG	$75,675	x				x								• Tenderloin, South of Market, and 6th Street neighborhoods
			VBIO	$148,463	x				x								
			EVAL	$4,000													
	CDCsup	$15,000	IRRC	$15,000	x	x				x							
Central City Hospitality House	General	$74,820	SSG	$45,620	x	x	x	x	x	x	x						• Homeless and runaway youth ages 15-21 • Tenderloin, Civic Center, Polk Gulch and Mission neighborhoods • Latino component
			IRRC	$21,682	x	x	x	x	x	x	x						
			EVAL	$7,518													
City Clinic (SFDPH)	CDC	$561,773	CTRPN	$561,773	x	x	x	x	x	x	x	x	x	x	x	x	• Low income • Sexually transmitted diseases
			EVAL	$0													

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
Filipino Task Force On AIDS	General	$60,290	MSG	$33,373			x	x									• Filipino
			PCM	$18,796			x	x									
			EVAL	$8,121													
	CDCsup	$15,000	MSG	$5,002			x	x									• Filipino
			VBGO	$5,000			x	x									• Youth under 24 years
			Media	$4,998			x	x									
Forensic AIDS Project (SFDPH)	CDC	$360,602	SSG	$112,560	x	x	x	x	x	x	x	x	x	x	x	x	• Incarcerated Adults
			CTRPN	$248,042	x	x	x	x	x	x	x	x	x	x	x	x	
			EVAL	$0													
Glide-Goodlet	State	$232,487	Start-up	$25,800													• Low-Income
			MSG	$29,383	x	x			x	x							• Tenderloin neighborhood
			PCM	$108,864	x	x			x	x							
			VBIO	$55,240	x	x			x	x							
			EVAL	$13,200													
	CDC	$42,467	CTRPN	$37,756	x	x			x	x							
			EVAL	$4,710													
HAFCI-Medical	CDC	$83,282	CTRPN	$72,584	x	x	x	x	x	x	x	x	x	x	x	x	• Substance use
			EVAL	$10,698													• Low-income
HAFCI/ HAYOT	CDCsup	$10,000	IRRC	$10,000	x	x				x							• Upper Haight and Golden Gate Park neighborhood
HAFCI/ WNC	CDC	$62,831	VBIO	$62,831					x		x			x			• Low Income • African American • Latina

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
ICHO	CDC	$249,714	VBIO	$249,738	x	x	x	x	x	x	x	x	x	x	x	x	• Bayview Hunter's Point, OMI, Potrero Hill, Mission, Civic Center, Tenderloin, Western Addition, and Sunnydale neighborhoods
			EVAL	$0													
	CDCsup	$35,000	IRRC	$12,830	x	x			x	x	x	x					
				$14,961			x	x									• Native American • African American
				$7,209			x	x							x		• Latino • Immigrant, homeless & indigent
IFR	CDCsup	$25,000	IRRC	$12,487	x	x				x							• Latino • Immigrant • Mission neighborhood • Monolingual
				$12,399			x	x									• Latino • Immigrant, migrant, and indigent • Monolingual

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
Iris	CDC	$33,333	VBIO	$33,336					x		x	x	x	x		x	• Low Income • Commercial sex work • Substance Use
	State	$127,747	IRRC	$18,499					x		x	x	x	x		x	
			MSG	$30,324					x		x	x	x	x		x	
			SSG	$36,730					x		x	x	x	x		x	
			VBGO	$18,050					x		x	x	x	x		x	
			E VAL	$24,144													
	CDCsup	$20,000	IRRC	$20,000					x		x	x					
Larkin Street	General	$108,477	IRRC	$45,483	x	x	x	x	x								• Homeless and Runaway youth 14 -21 years • Polk Gulch, Tenderloin, Haight Ashbury neighborhoods
			MSG	$53,350	x	x	x	x	x								
			VBIO	$3,941	x	x	x	x	x								
			EVAL	$5,703													
LYRIC	State & General	$103,000	MSG	$17,951			x	x									• Youth under 25
			VBGO	$9,845			x	x									
			MSG	$55,920			x	x									
			SSG	$5949			x	x									
			EVAL	$13,335													
	CDCsup	$50,000	MSG	$23,445				x	x								
			VBGO	$14,822				x	x								
			Media	$11,133				x	x								

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
Mission Neighborhood Health Center	CDC	$107, 169	PCM	$13,772			x										• Latino • Immigrants • Monolingual • Mission neighborhood
			MSG	$75,273			x										
			EVAL	$18, 124													
	CDCd	$113,100	MSG				x	x					x	x	x	x	• Youth under 18 • Latino
NAAP- (NTFAP)	General	$135,363	MSG	$60,515	x		x		x	x							• Native American
			VBGO	$55,556	x		x		x	x							
			EVAL	$19,292													
New Village (NTFAP)	General	$224,821	MSG	$63,858	x	x	x										• African American • Transgender
			SSG	$63,260	x	x	x										
			VBGO	$48,738	x	x	x										
			EVAL	$48,964													
	CDCsup	$15,000	IRRC	$15,000				x	x								
Polaris Research and Development	CDC	$254,975	Logistical and Technical Support	$254,975													• Logistical and technical support for council and HIV consensus meeting
	CDCsup	$49,000	Media	$49,000	x	x	x	x	x	x	x	x	x	x			• Post-exposure prophlaxis • Other media and focus groups

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
Proyecto Contra SIDA por VIDA (NTFAP)	General	$190,737	IRRC	$39,042	x		x	x			x						• Latino • Transgender • Youth component • Mission neighborhood • Immigrant • Monolingual
			MSG	$39,463	x		x	x			x						
			SSG	$39,468	x		x	x			x						
			VBGO	$42,014	x		x	x			x						
			EVAL	$30,748													
	CDCsup	$35,000	MSG	$10,672				x	x								• Youth under 24 years • Latino
			VBGO	$7,232				x	x								
			Media	$17,096				x	x								
SFAF	General	$131,149	Hotline	$131,040	x	x	x	x	x	x	x	x	x	x	x	x	
		$505,721	VBGO	$117,040	x		x										• African American component • Tenderloin neighborhood component • Low-income component
			Media	$79,068	x		x										
			MSG	$55,248	x		x										
			PCM	$158,328	x		x										
			SSG	$75,450	x		x										
			EVAL	$20,585													
SFAF/HPP	CDC	$100,000	NE	$99,998	x	x			x	x	x	x					
			EVAL	$0													
	General	$574,956	NE	$569,739	x	x			x	x	x	x					
			EVAL	$5,213													

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
SFGH (SFDPH)	CDC	$16,500	Hotline	$16,499	Occupational Risk												• Needle stick hotline
	CDC/ST	$164,915	CTRPN	$164,908	x	x	x	x	x	x	x	x	x	x	x	x	• Low-income
			EVAL	$0													
SEACC	CDCsup	$10,000	IRRC	$10,000			x	x							x		• API • Transgender • Immigrant • Commercial sex workers
SPY (SFDPH)	CDC	$193,934	CTRPN	$60,117	x	x	x	x	x	x	x	x	x	x	x	x	• Incarcerated youth
			IRRC	$126,045	x		x		x	x				x	x		
			MSG	$1,880	x		x		x	x				x	x		
			SSG	$5,876	x		x		x	x				x	x		
			EVAL	$0													
Prevention Training Center (SFDPH)	CDC	$204,078	MSG	$7,568	x	x	x	x	x	x	x	x	x	x	x	x	• African American faith community
			SSG	$8,163	x	x	x	x	x	x	x	x	x	x	x	x	
			Training	$116,919													• HIV Prevention Providers
			EVAL	$71,429													

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
STOP AIDS Project	CDC	$204,856	VBIO	$172,261	x		x	x									• Castro, Polk Gulch and South of Market neighborhoods
			EVAL	$32,599													
	General	$500,029	VBIO	$65,622	x		x	x									• Youth component (under 24)
			IRRC	$87,820	x		x	x									
			Media	$86,854	x		x	x									
			SSG	$81,383	x		x	x									
			VBGO	$84,246	x		x	x									
			EVAL	$84,404													
		$150,000	Cond. Dist.	$150,000	x	x	x	x									• Gay bars, sex clubs in Castro, Polk, SoMa, and Tenderloin
	CDCsup	$45,000	MSG	$6,476			x	x									• Youth under 24 years
			VBGO	$1,792			x	x									• Latino focus
			Media	$11,732			x	x									
			Media	$25,000			x	x									• Speed users
	CDCd	$258,003	Media				x	x									• Youth component
			SSG				x	x									
			VBGO				x	x									
			VBIO				x	x									
Support Center	CDC	$116,165	Org. Develop. & Capacity Bldg.	$116,165													• Organizational Development & evaluation capacity building

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
TARC	CDC	$166,224	MSG	$61,626	x		x		x					x			• Transgender • Low-income • Commercial sex workers • Tenderloin neighborhood • Indigent and homeless
			VBGO	$49,211	x		x		x					x			
			VBIO	$50,555	x		x		x					x			
			EVAL	$4,832													
Urban Health Study (UCSF)	CDC	$575,265	SSG	$65,605	x	x			x	x	x	x					• Substance use • Low-income
			IRRC	$219,639	x	x			x	x	x	x					
			CTRPN	$220,274	x	x			x	x	x	x					
			EVAL	$69,747													
	CDCsup	$30,000	IRRC	$30,000	x	x			x	x	x	x					
Wedge (SFDPH)	CDC	$367,016	MSG	$367,012	x	x	x	x	x	x	x	x	x	x	x	x	• In-school youth (Middle and High School)
			EVAL	$0													
	CDCsup	$15,000	MSG	$4,500			x	x									
			VBGO	$6,000			x	x									
			Media	$4,500			x	x									

AGENCY	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
Westside	General	$130,812	Start-up	$21,802										x			• Women of Color
			MSG	$109,008										x			
			EVAL	$0													
YUTHE (SFDPH)	State	$143,980	IRRC	$23,067										x	x		• Youth 12-22 years
			MSG	$57,592										x	x		• African American
			VBIO	$34,555										x	x		• Sexually transmitted diseases
			EVAL	$28,796													

Agencies in collaborations or sub-contracting relationships

Agency	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
APIWC & FTFA	CDCd	$261,100															
APIWC		$214,972	Media		x		x	x									• API
			SSG		x	x		x									• Youth component
			VBGO		x	x		x									• Transgender
FTFA		$46,128	Media				x	x									• Filipino
			VBGO				x	x									
IFR/ Aguilas	CDC	$187,743															
IFR			MSG	$60,391			x	x									• Latino
			VBGO	$59,764			x	x									• Immigrant
			EVAL	$18,118													• Mission neighborhood
Aguilas			MSG	$30,923			x	x									• Monolingual
			SSG	$8,246			x	x									
			EVAL	$10,308													

Agency	Funding Source	Amount of Contract	Interventions	Cost of Intervention	Behavioral Risk Populations												Co-variates & Co-factors
					1	2	3	4	5	6	7	8	9	10	11	12	
IFR/RAP	General	$71,188															
IFR			VBGO	$33,494										x			• Latino
			EVAL	$2,100										x			• Immigrant • Mission neighborhood • Monolingual
RAP			VBGO	$33,494										x	x		• Youth
			EVAL	$2,100													• Mission neighborhood • Immigrant
HAFCI/WNC-Detox	State	$339,031															
WNC			PCM	$101,583					x		x			x			• Low-income
			VBIO	$85,210					x		x			x			• African American
			EVAL	$4,031													• Latina
Detox			PCM	$101,583	x		x										• Substance use
			VBIO	$41,683	x		x										
			EVAL	$6,784													

EXHIBIT 2 FUNDING BY INTERVENTION TYPE

The table below is organized by intervention type. From this exhibit it is possible to see which providers are currently implementing prevention interventions, the cost of each intervention, and the BRPs that are targeted by that intervention. The interventions list is taken from the 1997 Plan. In addition to interventions included in the Plan, training services for providers, condom distribution, and evaluation are included. The interventions are further broken down by agency, funding source, BRPs, and co-variates and co-factors. As stated previously, it should not be assumed that agencies that target multiple BRPs, are reaching all BRPs equally. For agencies receiving CDC Direct funding and providing multiple interventions, it is not possible to calculate the cost of the intervention.

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
Condom Distribution	Stop AIDS	General	$150,000	x	x	x	x									• Gay bars, sex clubs in Castro, Polk, SoMa, and Tenderloin
Counseling, Testing, Referral, & Partner Notification (CTRPN)	AIDS Health Project (UCSF)	State	$436,560	x	x	x	x	x	x	x	x	x	x	x	x	
		CDC	$383,374	x	x	x	x	x	x	x	x	x	x	x	x	
	Bureau Family Health (SFDPH)	CDC	$176,248	x	x	x	x	x	x	x	x	x	x	x	x	• Low income
	City Clinic (SFDPH)	CDC	$561,773	x	x	x	x	x	x	x	x	x	x	x	x	• Low income • STDs
	FAP (SFDPH)	CDC	$248,042	x	x	x	x	x	x	x	x	x	x	x	x	• Incarcerated adults
	Glide	CDC	$37,756	x	x			x	x							• Tenderloin • Low income
	HAFCI/ Medical	CDC	$72,584			x	x					x			x	• Substance use • Low income
	SFGH (SFDPH)	CDC	$164,908			x	x	x	x				x			• Low income
	SPY (SFDPH)	CDC	$60,117	x	x	x	x	x	x	x	x	x	x	x	x	• Incarcerated youth
	Urban Health Study (UCSF)	CDC	$220,274	x	x			x	x	x	x					• Substance use • Low income
Hotline	SFAF	General	$131,040	x	x	x	x	x	x	x	x	x	x	x	x	
	SFGH (SFDPH)	CDC	$16,499	Occupational Risk												• Needle stick hotline

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
INDIVIDUAL RISK REDUCTION COUNSELING (IRRC)	AIDS Health Project (UCSF)	State	$58,330			x	x									• Over 25 years
	API Wellness Center	CDC	$42,642	x		x	x									• API • Transgender • Monolingual • Immigrant
		General	$7,963	x		x										
		CDCsup	$5,000	x	x			x	x	x	x					
			10,000			x	x							x		
	Black Coalition on AIDS	CDCsup	$20,000	x	x			x	x	x	x					• African American • Bayview Hunter's Point/ 3 Street, Double Rock, Potrero and Castro neighborhood
	CAITC/ ICHO	CDC	$76,416					x		x						• Native American, Latina, and African American
	CAL PEP	CDCsup	$15,000	x	x				x							• Tenderloin, South of Market, and 6th Street neighborhoods
	Central City Hosp. House	General	$21,682	x	x	x	x	x	x	x						• Homeless and runaway youth 15-21 years old • Tenderloin, Polk gulch, civic Center and Mission neighborhoods
	HAFCI/ HAYOT	CDCsup	$10,000	x	x				x							• Upper Haight and Golden Gate Park neighborhood
	ICHO	CDCsup	$12,830	x	x			x	x	x	x					• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
			$14,961			x	x									• Native American • African American
			$7,209			x	x							x		• Latino • Immigrant, homeless & indigent

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
IRRC (continued)	IFR	CDCsup	$12,487	x	x				x							• Latino • Immigrant • Mission neighborhood • Monolingual
			$12,399			x	x							x		• Immigrant, migrant, and indigent Latinos
	Iris/Life Works	State	$18,499					x		x	x	x	x		x	• Low income • Substance use
		CDCsup	$20,000					x		x	x					• Commercial sex workers
	Larkin Street	General	$45,483	x	x	x	x	x								• Homeless and runaway youth 14-21 years Tenderloin, Polk Gulch and • Haight Ashbury neighborhoods
	New Village (NTFAP)	CDCsup	$15,000			x	x									• African American
	Proyecto (NTFAP)	General	$39,042	x		x	x			x						• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual • Youth component
	SEACC	CDCsup	$10,000			x	x							x		• API • Transgender • Immigrant • Commercial sex workers
	SPY (SFDPH)	CDC	$126,045	x		x		x	x				x	x		• Incarcerated youth
	Stop AIDS	General	$87,820	x		x	x									• Youth (under 25) component
	Urban Health Study (UCSF)	CDC	$219,639	x	x	x	x	x	x	x	x					• Substance use • Low income
		CDCsup	$30,000	x	x			x	x	x	x					
	YUTHE	State	$23,037										x	x		• African American focus • Youth 12-22 years • STDs

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
Media	API Wellness Center	CDCd		x		x	x									• API • Immigrant • Monolingual • Youth component
		CDCsup	$4,381			x	x									• API • Youth under 24 years
	FTFA	CDCsup	$4,998			x	x									• Filipino • Youth under 24
		CDCd				x	x									• Filipino
	LYRIC	CDCsup	$11,133			x	x									• Youth under 24
	Polaris Research	CDCsup	$49,000	x	x	x	x	x	x	x	x	x	x			• Post exposure prophylaxis • Other media development
	Proyecto (NTFAP)	CDCsup	$17,096			x	x									• Latino • Youth under 24
	SFAF	General	$79,068	x		x										
	Stop AIDS	General	$86,854	x		x	x									• Youth (under 25) component
		CDCsup	$11,732			x	x									• Latino youth under 24
			$25,000	x		x	x									• Speed users
		CDCd				x	x									• Youth (under 25) component
	Wedge (SFDPH)	CDCsup	$4,500			x	x									• In-school youth
Multiple Session Groups (MSG)	AIDS Health Project (UCSF)	State	$34,201			x										• Over 25 years
	API Wellness Center	CDC	$166,938	x		x	x									• API • Transgender
		General	$31,161	x		x	x									• Monolingual • Immigrant
		CDCsup	$9,477			x	x									• API • Youth under 24 years
	Black Coalition on AIDS	State	$37,003		x	x		x								• African American • Bayview Hunter's Point 3 Street, Castro neighborhood
	CAITC/ ICHO	CDC	$43,917					x		x						• Native American, Latina, and African American
	FTFA	General	$33,373			x	x									• Filipino
		CDCsup	$5,002			x	x									• Filipino • Youth under 24
	Glide	State	$29,383	x	x			x	x							• Tenderloin • Low income

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
MSG continued	IFR	CDC	$60,391			x	x									• Latino • Immigrant
	Agullas	CDC	$30,923			x	x									• Mission neighborhood • Monolingual
	Iris	State	$30,324					x		x	x	x	x		x	• Low income • Substance use • Commercial sex workers
	Larkin Street	General	$53,350	x	x	x	x	x								• Homeless and runaway youth 14-21 years Tenderloin, Polk Gulch and • Haight Ashbury neighborhoods
	LYRIC	State & General	$55,920			x	x									• Youth under 25 years
		CDCsup	$23,445			x	x									
	Mission Neighborhood Health	CDC	$75,273			x										• Latino • Immigrant • Mission neighborhood • Monolingual
		CDCd	$113,100			x	x					x	x	x	x	• Youth under 18 years • Latino • Mission neighborhood
	NAAP (NTFAP)	General	$60,515	x		x		x	x							• Native American
	New Village (NTFAP)	General	$63,858	x	x	x										• African American
	Proyecto (NTFAP)	General	$39,463			x	x			x						• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual • Youth component
		CDCsup	$10,672			x	x									• Youth under 24 years • Latino
	SFAF	General	$55,248	x		x										• African American component Low income component • Tenderloin component
	SPY (SFDPH)	CDC	$1,880	x		x		x	x				x	x		• Incarcerated youth
	Prev. Training Center (SFDPH)	CDC	$7,568	x	x	x	x	x	x	x	x	x	x	x	x	• African American faith community

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
Multiple Session Groups continued	STOP AIDS	CDCsup	$6,476			x	x									• Youth under 25 years
	TARC	CDC	$61,626	x		x		x					x			• Tenderloin • Indigent and homeless Low income Transgender • Commercial sex workers
	Wedge (SFDPH)	CDC	$367,012	x	x	x	x	x	x	x	x	x	x	x	x	• In-school youth
		CDCsup	$4,500	x	x	x	x	x	x	x	x	x	x	x	x	
	Westside	General	$109,008										x			• Women of color
	YUTHE	State	$57,592										x	x		• African American focus • Youth 12-22 years • STDs
Needle Exchange	SFAF/HPP	CDC	$99,998	x	x			x	x	x	x					
		General	$569,739	x	x			x	x	x	x					
Prevention Case Management (PCM)	FTFA	General	$18,796			x	x									• Filipino
	Glide	State	$108,864	x	x			x	x							• Tenderloin • Low income
	WNC	State	$101,583					x		x			x			• Low income • African American and Latina • Western Addition and Mission neighborhoods
	HAFCI/WNC--Detox	State	$101,583	x		x										• Substance use
	Mission Neighborhood Health	CDC	$13,772			x										• Latino • Immigrant • Mission neighborhood • Monolingual
	SFAF	General	$158,328	x		x										• African American component Low income component • Tenderloin component
Single Session Groups (SSG)	AIDS Health Project (UCSF)	State	$40,640			x										
	API Wellness Center	CDC	$13,606	x		x	x									• API • Transgender
		General	$2,538	x		x	x									• Monolingual • Immigrant
	APIWC/FTFA	CDCd				x	x									• API • Youth component

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
Single Session Groups (SSG)	Black Coalition on AIDS	State	$37,003		x	x		x								• African American • Bayview Hunter's Point/ 3 Street, Castro neighborhood
	CAITC/ ICHO	CDC	$14,563					x		x						• Native American, Latina, and African American
	CAL PEP	CDC	$75,675	x				x								• SoMa, 6th Street, and Tenderloin neighborhood
	Central City Hosp. House	General	$45,620	x	x	x	x	x	x	x						• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhoods Latino component
	FAP (SFDPH)	CDC	$112,560	x	x	x	x	x	x	x	x	x	x	x	x	• Incarcerated adults
	Aguilas	CDC	$8,246			x	x									• Latino • Immigrant • Mission neighborhood • Monolingual
	Iris/Life Works	State	$36,730					x		x	x	x	x		x	• Low income • Substance use • Commercial sex workers
	LYRIC	State	$17,951			x	x									• Youth under 25 years
		General	$5,949			x	x									
	New Village (NTFAP)	General	$63,260	x	x	x										• African American
	Proyecto (NTFAP)	General	$39,468	x		x	x			x						• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual
	SFAF	General	$75,450	x		x										• African American component Low income component • Tenderloin component
	SPY (SFDPH)	CDC	$5,876	x		x		x	x				x	x		• Incarcerated youth
	Prev. Training Center	CDC	$8,163	x	x	x	x	x	x	x	x	x	x	x	x	• African American faith community
	Stop AIDS	General	$81,383	x		x	x									• Youth (under 25) component
		CDCd				x	x									

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
Single Session Group (SSG)	Urban Health Study (UCSF)	CDC	$65,605	x	x			x	x	x	x					• Substance use • Low income
Training	AIDS Health Project (UCSF)	CDC	$100,001													
	STD Prev. Training Center	CDC	$116,919													
Venue-Based Group Outreach (VBGO)	API Wellness Center	CDCsup	$3,080			x	x									• API • Youth under 24 years
	APIWC	CDCd				x	x									• API • Youth component
	FTFA	CDCsup	$5,000			x	x									• Filipino • Youth under 24
	FTFA	CDCd				x	x									• Filipino
	IFR	CDC	$59,764			x	x									• Latino • Immigrant
		General	$33,494										x			• Mission neighborhood • Monolingual
	RAP	General	$33,494										x	x		• Latino • Immigrant • Mission neighborhood • Monolingual • Youth
	Iris	State	$18,499					x	x	x		x	x		x	• Low income • Substance use • Commercial sex workers
	LYRIC	General	$9,845			x	x									• Youth under 25 years
		CDCsup	$14,822			x	x									• Youth under 24
	NAAP (NTFAP)	General	$55,556	x		x		x	x							• Native American
	New Village (NTFAP)	General	$48,738	x	x	x										• African American
	Proyecto (NTFAP)	General	$42,014	x		x	x									• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual
		CDCsup	$7,232			x	x									• Latino • Youth under 24
	SFAF	General	$117,040	x		x										• African American component Low income component • Tenderloin component

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
Venue-based Group Outreach (VBGO)	Stop AIDS	General	$84,246	x		x	x									• Youth (under 25) component
		CDCd				x	x									
		CDCsup	$1,792			x	x									• Latino youth under 24
	TARC	CDC	$49,211	x		x		x					x			• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
	Wedge (SFDPH)	CDCsup	$6,000			x	x									• In-school youth
Venue-Based Individual Outreach (VBIO)	API Wellness Center	CDC	$80,037	x		x	x									• API • Transgender
		General	$14,942	x		x	x									• Monolingual • Immigrant
	Black Coalition on AIDS	State	$123,338		x	x		x								• African American • Bayview Hunter's Point/ 3 Street, Potrero Hill, and Castro neighborhood
	CAL PEP	CDC	$148,463	x				x								• SoMa, 6th Street and Tenderloin neighborhood
	Glide	State	$55,240	x	x			x	x							• Tenderloin • Low income
	HAFCI/WNC	CDC	$62,831					x		x	x	x	x		x	• Low income • African American and Latina
		State	$85,210					x		x			x			• Western Addition and Mission neighborhood
	HAFCI/Detox	State	$41,683	x		x										• Substance use
	ICHO	CDC	$249,738	x	x	x	x	x	x	x	x	x	x	x	x	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
	Iris	CDC	$33,336					x		x	x	x	x		x	• Low income • Substance use • Commercial sex workers
	Larkin Street	General	$3,941	x	x	x	x	x								• Homeless and runaway youth 14-21 years Tenderloin, Polk Gulch and • Haight Ashbury neighborhoods

Interventions	Agency	Funding Source	Cost of Intervention	Behavioral Risk Populations												Co-variates and Co-factors
				1	2	3	4	5	6	7	8	9	10	11	12	
Venue-based Individual Outreach (VBIO)	Stop AIDS	CDC	$172,261	x		x	x									• Youth (under 25) component
		General	$65,622	x		x	x									
		CDCd				x	x									
	TARC	CDC	$50,555	x		x		x					x			• Tenderloin • Indigent and homeless Low income Transgender • Commercial sex workers • African American focus • Youth 12-22 years • STDs
	YUTHE	State	$34,555										x	x		

Interventions	Agency	Funding Source	Cost of Intervention	Agency	Funding Source	Cost of Intervention
Evaluation	AIDS Health Project (UCSF)	State	$43,742	IFR	General	$2,100
		CDC	$81,163	RAP	General	$2,100
	API Wellness Center	General	$10,367	Iris/Life Works	State	$24,144
		CDC	$46,760	Larkin Street	General	$5,703
	Black Coalition on AIDS	State	$49,339	LYRIC	General	$13,335
	Bureau Family Health (SFDPH)	CDC	$7,308	Mission Neighborhood Health	CDC	$18,124
	CAITC/ ICHO	CDC	$10,282	NAAP (NTFAP)	General	$19,292
	CAL PEP	CDC	$4,000	New Village (NTFAP)	General	$48,964
	Central City Hosp. House	General	$7,518	Proyecto (NTFAP)	General	$30,748
	FTFA	General	$8,121	SFAF	General	$20,585
	Glide	CDC	$4,710	SFAF/HPP	General	$5,213
		State	$13,200	STD Prev. Training Center	CDC	$71,429
	HAFCI/ Medical	CDC	$10,698	Stop AIDS	General	$84,404
	HAFCI/WNC-	State	$4,031	Stop AIDS	CDC	$32,599
	HAFCI/Detox	State	$6,784	TARC	CDC	$4,832
	IFR	CDC	$18,118	Urban Health Study (UCSF)	CDC	$69,747
	Aguilas	CDC	$10,307	YUTHE (SFDPH)	State	$28,796

EXHIBIT 3 SERVICES BY BRP

This table lists HIV prevention services by BRP. It is further broken down by intervention, agency providing the intervention, funding source, and co-variates and co-factors.

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #1 MSM-IDU	Condom Distribution	STOP AIDS	General	• Gay bars and sex clubs in Castro, Polk, SoMa, and Tenderloin
	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	CDC	
			State	
		Bureau Family Health (SFDPH)	CDC	• Low income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		Glide	CDC	• Tenderloin • Low income
		HAFCI/ Medical	CDC	• Substance use • Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	API Wellness Center	CDC	• API • Transgender • Monolingual • Immigrant
			CDCsup	
		Black Coalition on AIDS	CDCsup	• African American • Bayview Hunter's Point/ 3 Street, Double Rock, Potrero and Castro neighborhood
		CAL PEP	CDCsup	• Tenderloin, South of Market, and 6th Street neighborhoods
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood
		HAFCI/HAYOT	CDCsup	• Upper Haight and Golden Gate Park neighborhood
		ICHO	CDCsup	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		IFR	CDCsup	• Latino, • Immigrant • Mission neighborhood • Monolingual
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #1 MSM-IDU	Individual Risk Reduction Counseling (IRRC)	Proyecto (NTFAP) Contra SIDA	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual • Youth component
		SPY (SFDPH)	CDC	• Incarcerated youth
		STOP AIDS	General	• Youth (under 25) component
		Urban Health Study (UCSF)	CDC	• Substance use
			CDCsup	• Low income
	Media	**APIWC**/FTFA	CDCd	• API • Youth component • Monolingual • Immigrant • Transgender
		SFAF	General	
		STOP AIDS	General	• Youth (under 25) component
	Multiple Session Groups (MSG)	API Wellness Center	CDC	• API • Transgender
			General	• Monolingual • Immigrant
		Glide	State	• Tenderloin • Low income
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		NAAP (NTFAP)	General	• Native American
		New Village (NTFAP)	General	• African American
		SFAF	General	• Low-income component • African American component • Tenderloin neighborhood component
		SPY (SFDPH)	CDC	• Incarcerated youth
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
		Wedge (SFDPH)	CDC	• In-school youth
	Needle Exchange	SFAF/HPP	CDC	
			General	
	Prevention Case Management (PCM)	Glide	State	• Tenderloin • Low income
		HAFCI/WNC--Detox	State	• Substance use
		SFAF	General	• Low-income component • African American component • Tenderloin neighborhood component

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #1 MSM-IDU	Single Session Groups (SSG)	API Wellness Center	CDC	• API • Transgender
			General	• Monolingual • Immigrant
		APIWC/FTFA	CDCd	• API • Transgender • Monolingual • Immigrant • Youth component
		CAL PEP	CDC	• SoMa, 6th Street and Tenderloin
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood • Latino group
		FAP (SFDPH)	CDC	• Incarcerated adults
		New Village (NTFAP)	General	• African American
		Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual • Youth component
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		STOP AIDS	General	• Youth component
		SPY (SFDPH)	CDC	• Incarcerated youth
		SFAF	General	• Low-income component • African American component • Tenderloin neighborhood component
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Venue-based Group Outreach (VBGO)	**APIWC**/FTFA	CDCd	• API • Transgender • Monolingual • Immigrant • Youth component
		NAAP (NTFAP)	General	• Native American
		New Village (NTFAP)	General	• African American
		Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
		SFAF	General	• Low-income component • African American component • Tenderloin neighborhood component
		STOP AIDS	General	• Youth component

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #1 MSM-IDU	Venue-based Individual Outreach (VBIO)	API Wellness Center	CDC General	• API • Transgender • Monolingual • Immigrant
		CAL PEP	CDC	• SoMa, 6th Street and Tenderloin neighborhoods
		Glide	State	• Tenderloin • Low income
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Larkin Street	General	• Homeless & runaway youth 14-21 • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		STOP AIDS	General CDC	• Youth (under 25) component
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
BRP #2 MSM/F-IDU	Condom Distribution	STOP AIDS	General	• Gay bars and sex clubs in Castro, Polk, SoMa, and Tenderloin
	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	CDC State	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		Glide	CDC	• Tenderloin • Low income
		HAFCI/ Medical	CDC	• Substance use • Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	API Wellness Center	CDCsup	• API • Transgender • Monolingual • Immigrant
		Black Coalition on AIDS	CDCsup	• African American • Bayview Hunter's Point/ 3 Street, Double Rock, Potrero and Castro neighborhood
		CAL PEP	CDCsup	• Tenderloin, South of Market, and 6th Street neighborhoods

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #2 MSM/F-IDU	Individual Risk Reduction Counseling (IRRC)	Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood
		HAFCI/HAYOT	CDCsup	• Upper Haight and Golden Gate Park neighborhood
		ICHO	CDCsup	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		IFR	CDCsup	• Latino, • Immigrant • Mission neighborhood • Monolingual
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		Urban Health Study (UCSF)	CDC	• Substance use
	Multiple Session Groups (MSG)	Black Coalition on AIDS	State	• African American
		Glide	State	• Tenderloin • Low income
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		New Village (NTFAP)	General	• African American
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		Wedge (SFDPH)	CDC	• In-school youth
	Needle Exchange	SFAF/HPP	CDC General	
	Prevention Case Management	Glide	State	• Tenderloin • Low income
	Single Session Groups (SSG)	Black Coalition on AIDS	State	• African American
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood • Latino group
		FAP (SFDPH)	CDC	• Incarcerated adults
		New Village (NTFAP)	General	• African American
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Venue-based Group Outreach	New Village (NTFAP)	General	• African American

Behavioral Risk Population	Interventions	Agency	FUNDING Source	Co-variates and Co-factors
BRP #2 MSM/F-IDU	Venue-based Individual Outreach (VBIO)	Black Coalition on AIDS	State	• African American • Potrero Hill, Bayview Hunter's Point/3 Street, and Castro Neighborhood
		Glide	State	• Tenderloin • Low income
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
BRP #3 MSM	Condom Distribution	STOP AIDS	General	• Gay bars and sex clubs in Castro, Polk, SoMa, and Tenderloin
	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	CDC State	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		HAFCI/ Medical	CDC	• Substance use • Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
		SFGH (SFDPH)	CDC	• Low income
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	AIDS Health Project (UCSF)	State	• Over 25 years
		API Wellness Center	CDC General	• API • Transgender • Monolingual • Immigrant
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood
		ICHO	CDCsup	• Native American • African American • Latino • Immigrant, homeless & indigent
		IFR	CDCsup	• Immigrant, migrant, and indigent Latinos
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		New Village (NTFAP)	CDCsup	• African American

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #3 MSM	Individual Risk Reduction Counseling (IRRC)	Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual • Youth component
		SEACC	CDCsup	• API • Transgender • Immigrant • Commercial sex workers
		SPY (SFDPH)	CDC	• Incarcerated youth
		STOP AIDS	General	• Youth (under 25) component
	Media	API Wellness Center	CDCsup	• API • Youth under 24 years
		APIWC/FTFA	CDCd	• API • Transgender • Monolingual • Immigrant • Youth component
		FTFA	CDCsup	• Filipino • Youth under 24
		FTFA/APIWC	CDCd	• Filipino
		LYRIC	CDCsup	• Youth under 24
		Proyecto	CDCsup	• Latino • Youth under 24
		SFAF	General	
		STOP AIDS	CDCd	• Youth (under 25) component
			General	
			CDCsup	• Latino youth under 24
				• Speed users
		Wedge (SFDPH)	CDCsup	• In-school youth
	Multiple Session Groups (MSG)	AIDS Health Project (UCSF)	State	
		API Wellness Center	CDC	• API • Transgender
			General	• Monolingual • Immigrant
			CDCsup	• API • Youth under 24 years
		Black Coalition on AIDS	State	
		FTFA	General	• Filipino
			CDCsup	• Filipino • Youth under 24
		IFR/ Aguilas	CDC	• Latino • Immigrant
		Aguilas/IFR	CDC	• Mission neighborhood • Monolingual
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		LYRIC	General	• Youth under 25
			CDCsup	• Youth under 24

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #3 MSM	Multiple Session Groups (MSG)	Mission Neighborhood Health	CDC	• Latino • Mission neighborhood • Immigrant Monolingual
			CDCd	• Latino • Mission neighborhood • Immigrant • Monolingual • Youth under 18 years
		NAAP (NTFAP)	General	• Native American
		New Village (NTFAP)	General	• African American
		Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual • Youth component
			CDCsup	• Latino • Youth under 24
		SFAF	General	• Low-income component • African American component • Tenderloin neighborhood component
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth
		STOP AIDS	CDCsup	• Latino youth under 24
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
		Wedge (SFDPH)	CDC	• In-school youth
			CDCsup	
	Prevention Case Management (PCM)	FTFA	General	• Filipino
		HAFCI/WNC--Detox	State	• Substance use
		Mission Neighborhood Health	CDC	• Latino • Mission neighborhood • Immigrant • Monolingual
		SFAF	General	• Low-income component • African American component • Tenderloin neighborhood component
	Single Session Groups (SSG)	AIDS Health Project (UCSF)	State	
		API Wellness Center	CDC General	• API • Transgender • Monolingual • Immigrant

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #3 MSM	Single Session Groups (SSG)	**API**WC/FTFA	CDCd	• API • Transgender • Monolingual • Immigrant • Youth component
		Black Coalition on AIDS	State	• African American
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood • Latino component
		FAP (SFDPH)	CDC	• Incarcerated adults
		Aguilas/IFR	CDC	• Latino • Immigrant • Mission neighborhood Monolingual
		LYRIC	State General	• Youth under 25
		New Village (NTFAP)	General	• African American
		Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual
		SFAF	General	• Low-income component • African American component • Tenderloin neighborhood component
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth
		STOP AIDS	CDCd General	• Youth (under 25) component
	Venue-based Group Outreach (VBGO)	API Wellness Center	CDCsup	• API • Youth under 24 years
		APIWC/FTFA	CDCd	• API • Transgender • Monolingual • Immigrant • Youth component
		FTFA	CDCsup	• Filipino • Youth under 24
		FTFA/APIWC	CDCd	Filipino
		IFR/ Aguilas	CDC	• Latino • Immigrant • Mission neighborhood Monolingual
		LYRIC	General CDCsup	• Youth under 25 • Youth under 24
		NAAP (NTFAP) (NTFAP)	General	• Native American
		New Village (NTFAP)	General	• African American

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #3 MSM	Venue-based Group Outreach (VBGO)	Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual
			CDCsup	• Latino • Youth under 24
		SFAF	General	• Low-income component • African American component • Tenderloin neighborhood component
		STOP AIDS	CDCd	• Youth (under 25) component
			General	
			CDCsup	• Latino youth under 24
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
		Wedge (SFDPH)	CDCsup	• In-school youth
	Venue-based Individual Outreach (VBIO)	API Wellness Center	CDC	• API • Transgender
			General	• Monolingual • Immigrant
		Black Coalition on AIDS	State	• African American • Potrero Hill, Bayview Hunter's Point/3 Street, and Castro Neighborhood
		HAFCI/WNC--Detox	State	• Substance use
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		STOP AIDS	General	• Youth (under 25) component
			CDC	
			CDCd	
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #4 MSM/F	**Condom Distribution**	STOP AIDS	General	• Gay bars and sex clubs in Castro, Polk, SoMa, and Tenderloin
	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	State CDC	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		HAFCI/ Medical)	CDC	• Substance use • Low income
		SFGH (SFDPH)	CDC	• Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	API Wellness Center	CDC General	• API • Transgender • Monolingual • Immigrant
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood
		ICHO	CDCsup	• Native American • African American • Latino • Immigrant, homeless & indigent
		IFR	CDCsup	• Immigrant, migrant, and indigent Latinos
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		New Village (NTFAP)	CDCsup	• African American
		Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual
		SEACC	CDCsup	• API • Transgender • Immigrant • Commercial sex workers
		STOP AIDS	General	• Youth (under 25) component
	Media	API Wellness Center	CDCsup	• API • Youth under 24 years
		APIWC/FTFA	CDCd	• API • Transgender • Monolingual • Immigrant • Youth component
		FTFA	CDCsup	• Filipino • Youth under 24

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #4 MSM/F	Media	FTFA/APIWC	CDCd	• Filipino
		LYRIC	CDCsup	• Youth under 24
		Proyecto	CDCsup	• Latino • Youth under 24
		STOP AIDS	General	• Youth (under 25) component
			CDCd	
			CDCsup	• Latino youth under 24
				• Speed users
		Wedge (SFDPH)	CDCsup	• In-school youth
	Multiple Session Groups (MSG)	API Wellness Center	CDC	• API • Transgender
			General	• Monolingual • Immigrant
			CDCsup	• API • Youth under 24 years
		FTFA	General	• Filipino
			CDCsup	• Filipino • Youth under 24
		IFR/ Aguilas	CDC	• Latino • Immigrant
		Aguilas/IFR	CDC	• Mission neighborhood • Monolingual
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		LYRIC	General	• Youth under 25
			CDCsup	• Youth under 24
		Mission neighborhood	CDCd	• Latino • Mission neighborhood • Immigrant • Monolingual •
		Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual
			CDCsup	• Latino • Youth under 24
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		STOP AIDS	CDCsup	• Latino youth under 24
		Wedge (SFDPH)	CDC	• In-school youth
			CDCsup	
	Prevention Case Management	FTFA	General	• Filipino

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #4 MSM/F	Single Session Groups (SSG)	API Wellness Center	CDC	• API • Transgender • Monolingual • Immigrant
			General	
		APIWC/FTFA	CDCd	• API • Transgender • Monolingual • Immigrant • Youth component
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood • Latino component
		FAP (SFDPH)	CDC	• Incarcerated adults
		Aguilas/IFR	CDC	• Latino • Immigrant • Mission neighborhood Monolingual
		LYRIC	General	• Youth under 25
			State	
		Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		STOP AIDS	General	• Youth (under 25) component
			CDCd	
	Venue-based Group Outreach (VBGO)	API Wellness Center	CDCsup	• API • Youth under 24 years
		APIWC/FTFA	CDCd	• API • Transgender • Monolingual • Immigrant • Youth component
			CDCsup	• API • Youth under 24 years
		FTFA	CDCsup	• Filipino • Youth under 24
		FTFA/APIWC	CDCd	• Filipino
		IFR/ Aguilas	CDC	• Latino • Immigrant • Mission neighborhood Monolingual
		LYRIC	General	• Youth (under 25) component
			CDCsup	• Youth under 24
		Proyecto (NTFAP)	General	• Latino • Transgender • Mission neighborhood • Immigrant • Monolingual
			CDCsup	• Latino • Youth under 24

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #4 MSM/F	VBGO	STOP AIDS	CDCd General	• Youth (under 25) component
			CDCsup	• Latino youth under 24
		Wedge (SFDPH)	CDCsup	• In-school youth
	Venue-based Individual Outreach (VBIO)	API Wellness Center	CDC General	• API • Transgender • Monolingual • Immigrant
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		STOP AIDS	General CDCd CDC	• Youth (under 25) component
BRP #5 FSM-IDU	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	State CDC	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		Glide	CDC	• Tenderloin • Low income
		HAFCI/ Medical	CDC	• Substance use • Low income
		SFGH (SFDPH)	CDC	• Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	API Wellness Center	CDCsup	• API • Transgender • Monolingual • Immigrant
		Black Coalition on AIDS	CDCsup	• African American • Bayview Hunter's Point/ 3 Street, Double Rock, Potrero and Castro neighborhood
		CAITC/ ICHO	CDC	• Native American, Latina, and African American
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #5 FSM-IDU	Individual Risk Reduction Counseling (IRRC)	ICHO	CDCsup	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Ins/Life Works	State CDCsup	• Low income • Substance use • Commercial sex workers
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC CDCsup	• Substance use • Low income
	Multiple Session Groups (MSG)	Black Coalition on AIDS	State	• African American • Bayview Hunter's Point/ 3 Street
		CAITC/ ICHO	CDC	• Native American, Latina, and African American
		Glide	State	• Tenderloin • Low income
		Ins/Life Works	State	• Low income • Substance use • Commercial sex workers
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		NAAP (NTFAP)	General	• Native American
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
		Wedge (SFDPH)	CDC	• In-school youth
	Needle Exchange	SFAF/HPP	CDC General	
	Prevention Case Management (PCM)	Glide	State	• Tenderloin • Low income
		HAFCI–Detox/WNC	State	• Low income • African American and Latina • Western Addition and Mission neighborhoods

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #5 FSM-IDU	Single Session Groups (SSG)	Black Coalition on AIDS	State	• African American • Bayview Hunter's Point/ 3 Street
		CAITC/ ICHO	CDC	• Native American, Latina, and African American
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood • Latino component
		FAP (SFDPH)	CDC	• Incarcerated adults
		Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Venue-based Group Outreach (VBGO)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		NAAP (NTFAP)	General	• Native American
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
	Venue-based Individual Outreach (VBIO)	Black Coalition on AIDS	State	• African American • Potrero Hill and Bayview Hunter's Point/3 Street neighborhood
		Glide	State	• Tenderloin • Low income
		WNC/HAFC-Detox	State	• Low income • African American and Latina
		HAFCI/WNC	CDC	• Western Addition and Mission neighborhoods
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Iris	CDC	• Low income • Substance use • Commercial sex workers
		Larkin Street	General	• Homeless and runaway youth 14-21 years old • Tenderloin, Polk Gulch and Haight Ashbury neighborhood
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #6 MSF-IDU	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	State	
			CDC	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		Glide	CDC	• Tenderloin • Low income
		HAFCI/ Medical	CDC	• Substance use • Low income
		SFGH (SFDPH)	CDC	• Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	API Wellness Center	CDCsup	• API • Transgender • Monolingual • Immigrant
		Black Coalition on AIDS	CDCsup	• African American • Bayview Hunter's Point/ 3 Street, Double Rock, Potrero and Castro neighborhood
		CAL PEP	CDCsup	• Tenderloin, South of Market, and 6th Street neighborhoods
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood
		HAFCI/HAYOT	CDCsup	• Upper Haight and Golden Gate Park neighborhood
		ICHO	CDCsup	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		IFR	CDCsup	• Latino, • Immigrant • Mission neighborhood • Monolingual
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC	• Substance use
			CDCsup	• Low income
	Needle Exchange	SFAF/HPP (1/97-6/97)	CDC	
		SFAF/HPP (7/97-6/98)	General	

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #6 MSF-IDU	Multiple Session Groups (MSG)	Glide	State	• Tenderloin • Low income
		NAAP (NTFAP)	General	• Native American
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth
		Wedge (SFDPH)	CDC	• In-school youth
	Prevention Case Management	Glide	State	• Tenderloin • Low income
	Single Session Groups (SSG)	Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood • Latino component
		FAP (SFDPH)	CDC	• Incarcerated adults
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Venue-based Group Outreach	NAAP (NTFAP)	General	• Native American
	Venue-based Individual Outreach (VBIO)	Glide	State	• Tenderloin • Low income
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
BRP #7 FSF/M-IDU	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	State	
			CDC	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		HAFCI/ Medical	CDC	• Substance use • Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	API Wellness Center	CDCsup	• API • Transgender • Monolingual • Immigrant
		Black Coalition on AIDS	CDCsup	• African American • Bayview Hunter's Point/ 3 Street, Double Rock, Potrero and Castro neighborhood

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #7 FSF/M-IDU	Individual Risk Reduction Counseling (IRRC)	CAITC/ ICHO	CDC	• Native American, Latina, and African American
		Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood
		ICHO	CDCsup	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Iris/Life Works	State CDCsup	• Low income • Substance use • Commercial sex workers
		Proyecto (NTFAP)	General	• Latino • Mission neighborhood • Immigrant • Monolingual
		Urban Health Study (UCSF)	CDC CDCsup	• Substance use • Low income
	Multiple Session Groups (MSG)	CAITC/ ICHO	CDC	• Native American, Latina, and African American
		Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		Proyecto (NTFAP)	General	• Latino • Mission neighborhood • Immigrant Monolingual
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		Wedge (SFDPH)	CDC	• In-school youth
	Needle Exchange	SFAF/HPP (1/97-6/97)	CDC	
		SFAF/HPP (7/97-6/98)	General	
	Prevention Case Management	WNC/HAFCI--Detox	State	• Low income • African American and Latina • Western Addition and Mission neighborhoods
	Single Session Groups (SSG)	Central City Hosp. House	General	• Homeless and runaway youth 15-21 years old • Tenderloin, Polk Gulch, Civic Center and Mission neighborhood • Latino component
		Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		CAITC/ ICHO	CDC	• Native American, Latina, and African American
		FAP (SFDPH)	CDC	• Incarcerated adults
		Proyecto (NTFAP)	General	• Latino • Mission neighborhood • Immigrant Monolingual

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #7 FSF/M-IDU	Single Session Group (SSG)	Prev. Training Center (SFDPH)	CDC	• African American faith community
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Venue-based Group Outreach (VBGO)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
	Venue-based Individual Outreach (VBIO)	HAFCI/WNC		• Low income • African American and Latina
		WNC/HAFCI--Detox	State	• Western Addition and Mission neighborhoods
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Iris	CDC	• Low income • Substance use • Commercial sex workers
BRP #8 FSF-IDU	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	State	
			CDC	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		HAFCI/ Medical	CDC	• Substance use • Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	ICHO	CDCsup	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
			CDCsup	
		Urban Health Study (UCSF)	CDC	• Substance use
			CDCsup	• Low income
	Multiple Session Groups (MSG)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		Wedge (SFDPH)	CDC	• In-school youth
	Needle Exchange	SFAF/HPP (1/97-6/97)	CDC	
		SFAF/HPP (7/97-6/98)	General	

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #8 FSF-IDU	Single Session Groups (SSG)	FAP (SFDPH)	CDC	• Incarcerated adults
		Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		Urban Health Study (UCSF)	CDC	• Substance use • Low income
	Venue-based Group Outreach (VBGO)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
	Venue-based Individual Outreach (VBIO)	HAFCI/WNC	CDC	• Low income • African American and Latina Western Addition and Mission neighborhoods
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Iris	CDC	• Low income • Substance use • Commercial sex workers
BRP #9 FSF/M	Counseling, Testing, Referral, Partner Notification	AIDS Health Project (UCSF)	State CDC	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		HAFCI/ Medical	CDC	• Substance use • Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
	Multiple Session Groups (MSG)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		Mission Neighborhood Health	CDCd	• Latino • Mission neighborhood • Immigrant • Monolingual • Youth under 18 years
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		Wedge (SFDPH)	CDC	• In-school youth

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #9 FSF/M	Single Session Groups (SSG)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		FAP (SFDPH)	CDC	• Incarcerated adults
		Prev. Training Center (SFDPH)	CDC	• African American faith community
	Venue-based Group Outreach (VBGO)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
	Venue-based Individual Outreach (VBIO)	HAFCI/WNC	CDC	• Low income • African American and Latina Western Addition and Mission neighborhoods
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Iris	CDC	• Low income • Substance use • Commercial sex workers
BRP #10 FSM	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	State	
			CDC	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		HAFCI/ Medical	CDC	• Substance use • Low income
		SFGH (SFDPH)	CDC	• Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		SPY (SFDPH)	CDC	• Incarcerated youth
		YUTHE (SFDPH)	State	• African American focus • Youth 12-22 years • Sexually transmitted diseases
	Multiple Session Groups (MSG)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		Mission Neighborhood Health	CDCd	• Latino • Mission neighborhood • Immigrant • Monolingual • Youth under 18 years
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #10 FSM	Multiple Session Groups (MSG)	TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
		Wedge (SFDPH)	CDC	• In-school youth
		Westside	General	• Women of color
		YUTHE (SFDPH)	State	• African American focus • Youth 12-22 years • Sexually transmitted diseases
	Prevention Case Management	WNC/HAFC–Detox	State	• Low income • African American and Latina • Western Addition and Mission neighborhoods
	Single Session Groups (SSG)	FAP (SFDPH)	CDC	• Incarcerated adults
		Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth
	Venue-based Group Outreach (VBGO)	IFR/RAP	General	• Latino • Immigrant • Mission neighborhood Monolingual
		RAP/IFR	General	• Latino • Immigrant • Mission neighborhood • Monolingual Youth
		Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
	Venue-based Individual Outreach (VBIO)	WNC/HAFC–Detox	State	• Low income • African American and Latina
		HAFCI/WNC	CDC	• Western Addition and Mission neighborhoods
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Iris	CDC	• Low income • Substance use • Commercial sex workers

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #10 FSM	Venue-based Individual Outreach (VBIO)	TARC	CDC	• Tenderloin • Indigent and homeless • Low income • Transgender • Commercial sex workers
		YUTHE (SFDPH)	State	• African American focus • Youth 12-22 years • Sexually transmitted diseases
BRP #11 MSF	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	State	
			CDC	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		HAFCI/ Medical	CDC	• Substance use • Low income
		SFGH (SFDPH)	CDC	• Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	ICHO	CDCsup	• Latino • Immigrant, homeless & indigent
		IFR	CDCsup	• Immigrant, migrant, and indigent Latinos
		SEACC	CDCsup	• API • Transgender • Immigrant • Commercial sex workers
		SPY (SFDPH)	CDC	• Incarcerated youth
		YUTHE (SFDPH)	State	• African American focus • Youth 12-22 years • Sexually transmitted diseases
	Multiple Session Groups (MSG)	Mission Neighborhood Health	CDCd	• Latino • Mission neighborhood • Immigrant • Monolingual • Youth under 18 years
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth
		Wedge (SFDPH)	CDC	• In-school youth
		YUTHE (SFDPH)	State	• African American focus • Youth 12-22 years • Sexually transmitted diseases
	Single Session Groups (SSG)	FAP (SFDPH)	CDC	• Incarcerated adults
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		SPY (SFDPH)	CDC	• Incarcerated youth

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #11 MSF	Venue-based Group Outreach (VBGO)	IFR/RAP	General	• Latino • Immigrant • Mission neighborhood Monolingual
		RAP/IFR	General	• Latino • Immigrant • Mission neighborhood • Monolingual Youth
	Venue-based Individual Outreach (VBIO)	ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		YUTHE (SFDPH)	State	• African American focus • Youth 12-22 years • Sexually transmitted diseases
BRP #12 FSF	Counseling, Testing, Referral, Partner Notification (CTRPN)	AIDS Health Project (UCSF)	State	
			CDC	
		Bureau Family Health (SFDPH)	CDC	• Low-income
		City Clinic (SFDPH)	CDC	• Low income • STDs
		FAP (SFDPH)	CDC	• Incarcerated adults
		HAFCI/ Medical	CDC	• Substance use • Low income
		SFGH (SFDPH)	CDC	• Low income
		SPY (SFDPH)	CDC	• Incarcerated youth
	Hotline	SFAF	General	
	Individual Risk Reduction Counseling (IRRC)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
	Multiple Session Groups (MSG)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		Mission Neighborhood Health	CDCd	• Latino • Mission neighborhood • Immigrant • Monolingual • Youth under 18 years
		Prev. Training Center (SFDPH)	CDC	• African American faith community
		Wedge (SFDPH)	CDC	• In-school youth
	Single Session Groups (SSG)	FAP (SFDPH)	CDC	• Incarcerated adults
		Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
		Prev. Training Center (SFDPH)	CDC	• African American faith community

Behavioral Risk Population	Interventions	Agency	Funding Source	Co-variates and Co-factors
BRP #12 FSF	Venue-based Group Outreach (VBGO)	Iris/Life Works	State	• Low income • Substance use • Commercial sex workers
	Venue-based Individual Outreach (VBIO)	HAFCI/WNC	CDC	• Low income • African American and Latina • Western Addition and Mission neighborhoods
		ICHO	CDC	• Bayview Hunter's Point, Potrero Hill, Mission, OMI, Civic Center, Tenderloin, Western Addition, Visitation Valley, and Sunnydale neighborhoods
		Iris	CDC	• Low income • Substance use • Commercial sex workers

AGGRAGATE FUNDING BY BEHAVIORAL RISK POPULATIONS

Exhibit 4 provides a breakdown of aggregate funding amounts by Behavioral Risk Populations. When possible, aggregate funding was calculated for each BRP. However, most prevention providers target more than one BRP with their interventions and in some cases it was not possible to separate the funding amounts for each behavioral risk population. Based on recommendations in the 1997 Plan, in instances when it was not possible to separate funding amounts for each BRP, the BRPs were clustered into groups (*e.g.*, males who have sex with males; with males who have sex with males and females [BRP #3 and #4; or injection drug users (BRPs #1, #2, #5, #6, #7 & #8]). Combinations of BRPs that appeared only once in contracts were placed in the "Other" category (*e.g.*, the category of males who have sex with males; and the category of females who have sex with males and inject drugs). Each category is independent; funding amounts are not included in more than one row. Therefore, the total funding listed for each of the 12 BRP is less than the total funding for that BRP, because additional funds for that group are listed in one or more of the clusters below. It is important to note that this table does not include funding for evaluation or start-ups costs of prevention programs.

Exhibit 4 Estimated Funding by Behavioral Risk Populations (BRPs) or BRP Clusters

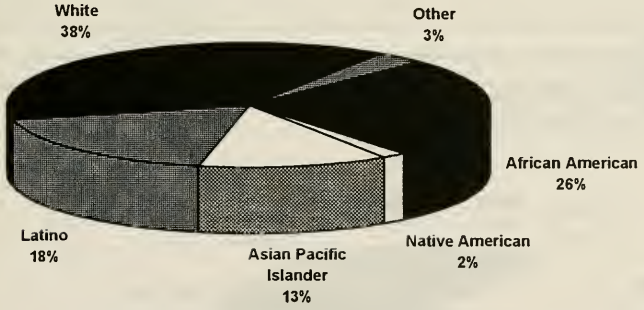
Behavioral Risk Population	Funding	
	$	%
#1 MSM-IDU	78,882	.8
#2 MSM/F-IDU	92,187	.9
#3 MSM	1,047,374	10.7
#4 MSM/F	282,643	2.9
#5 FSM-IDU	234,722	2.4
#6 MSF-IDU	326,372	3.3
#7 FSF/M-IDU	66,932	.7
#8 FSF-IDU	6,178	.1
#9 FSF/M	72,842	.7
#10 FSM	456,529	4.6
#11 MSF	255,445	2.7
#12 FSF	7,331	.1
BRPs 1-4: (MSM, MSM/F, MSM-IDU, & MSM/F-IDU)	2,449,961	25.0
BRPs 1-8: (MSM, MSM/F, MSM-IDU, MSM/F-IDU, FSM-IDU, FSF/M-IDU, FSF-IDU, & MSF-IDU)	225,630	2.3
BRPs 10 & 11: (FSM & MSF)	115,184	1.2
BRPs 5,7, 8, 9, 10, & 12 (Females): (FSM-IDU, FSF-IDU, FSF/M-IDU, FSM, FSF/M, & FSF)	323,732	3.3
BRPs 1,2,5,6,7 & 8 (IDUs): (FSM-IDU, FSF-IDU, FSF/M-IDU, FSM, FSF/M, & FSF)	1,400,724	14.2
BRPs 1-12: (MSM, MSM/F, MSM-IDU, MSM/F-IDU, FSM-IDU, FSF/M-IDU, FSF-IDU, MSF-IDU, FSF/M, FSF, FSM, & MSF)	1,722,178	17.5
All other BRP groupings	672,333	6.8
TOTAL FUNDS	$9,837,179	100

AGGREGATE FUNDING BY RACE/ETHNICITY

The table and chart in this exhibit contain the same information that represents aggregate funding by race and ethnicity for all prevention providers. Information for this exhibit was collected from AIDS Office contracts and is based on race and ethnic breakdown of clients served in the previous funding year, not clients who are currently being served. A small difference in the race and ethnicity of clients currently being served may exist; however, it is unlikely that these figures are significantly different from the previous year. Funding for evaluation and for the occupational needle stick hotline was not used in determining total amounts of funding by race and ethnicity.

Exhibit 5 Estimated Funding By Race Ethnicity

Race/Ethnicity	Funding	
	$	%
African American	2,480,209	26.3
Native American/ Alaskan Native	173,636	1.8
Asian Pacific Islander	1,190,529	12.6
Latino	1,708,316	18.1
White	3,580,548	38.0
Other	303,871	3.2



**Race and ethnic breakdowns of populations served by agencies were calculated from the 1997 Socio-Demographic form that each agency was required to submit to the AIDS Office as part of their contract. Does not include evaluation or Needle Stick Hotline funds.

AGGREGATE FUNDING BY INTERVENTION TYPE

The table and chart below contains the same information that represents aggregate funding amounts for interventions funded in 1997. The interventions list is from the Strategies and Interventions Chapter of the 1997 Plan with the addition of condom distribution, provider training, and evaluation. CDC Direct-funded agencies who provide multiple interventions were not included in the calculation of aggregate funding amounts for these interventions, as it was not possible to determine how much funding was directed to each intervention.

Exhibit 6 Estimated Funding by Intervention

Intervention	Funding	
	$	%
Condom Distribution	150,000	1.5
CTRPN	2,372,204	24.1
Hotlines	147,539	1.5
IRRC	984,552	10.0
Media	269,762	2.7
Multiple Session Groups	1,565,501	15.9
Needle Exchange	669,736	6.8
Prevention Case Management	502,926	5.1
Single Session Group	750,404	7.6
Training	216,920	2.2
VBGO	589,377	6.0
VBIO	1,222,673	12.4
Evaluation	743,340	7.5
Total Funds	**$9,854,934**	

Note: This amount will be different from the amount for BRPs because of the inclusion of evaluation and the exclusion of CDC Direct funded interventions.

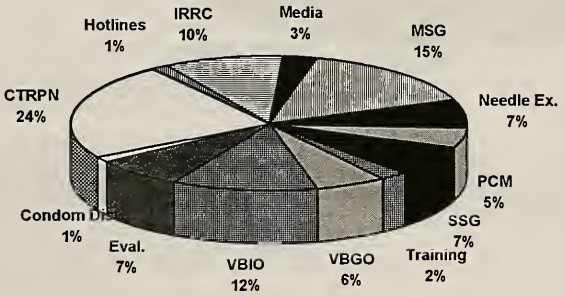


EXHIBIT 7 AGGREGATE FUNDING FOR YOUTH

This exhibit contains information on funding for youth (under 24 years old). It was not possible to accurately determine aggregate funding amounts for youth. Some providers have a youth-specific component, in addition to services for adults or target individuals who are 18 years and older. In these cases it was not possible to determine what percentage of funding was reaching youth and they were categorized as serving populations older than 18 years old. The amount of funding for youth is understated. Note that funding for evaluation is not included in this table.

Age group	Funding	
	$	%
Under 18 years	804,215	8.0
Under 24 years	478,795	4.7
Over 18 years	8,796,089	87.3

CHAPTER 5 - STRATEGIC EVALUATION

I. INTRODUCTION

Overview of the Chapter

The 1997 HIV Prevention Plan outlined a strategic evaluation and data collection plan for San Francisco designed to provide a blueprint for on-going evaluation efforts over a five year period. The five year strategic evaluation plan is divided into three areas or levels of evaluation research: 1) Level One- the prevention provider level; 2) Level Two- the intervention research level; 3) Level Three- the population-based prevention surveillance level. This plan provides clearly defined year-by-year objectives and tasks for each level of evaluation. The work of the Strategic Evaluation Committee for 1997 was determined by the objectives specified for Year One (1997) of the Strategic Evaluation Plan.

This chapter describes the work of the Strategic Evaluation committee during 1997. It includes an overview of the membership, the tasks and processes, the results of the committee work, and recommendations for work to be completed during 1998.

Committee Membership and Meetings

At the beginning of 1997, the committee was comprised of ten members: six council members, one community member, two AIDS Office staff, and one liaison from the SFDPH STD Prevention Training Center. During the year, membership changes occurred with one Council member resigning, one member taking a leave of absence from the Council, one AIDS Office staff limiting work with the committee due to a change in job responsibilities, and the community member being appointed to the Council and serving on the committee as a full Council member. By the end of the year, the Committee had seven members of whom five were Council members, one was AIDS Office staff, and one was a liaison from the STD Prevention Training Center. The committee was supported in their work by technical (*e.g.,* research, summarizing, and writing), logistical (*e.g.,* food and note taking) and evaluation (*e.g.,* process observation) consultants.

Over the year, the committee had four chairs who were responsible for working with AIDS Office staff and technical support consultants to set meeting agendas and guide the work of the committee. The first chair resigned from the Council and committee, the second chair was elected on an interim basis and subsequently took a leave of absence from the Council and two committee members were elected as co-chairs in July, and served out the rest of the year as committee co-chairs.

The Committee met 13 times during 1997 for meetings which were two to three hours in length. All decisions within the committee were made by consensus and if consensus was not possible, a vote was taken. During the first two meetings, members were oriented to the Strategic

Evaluation and Capacity Building Chapters. The committee was given an overview of the three levels of the Five Year Strategic Evaluation Plan and the tasks for the coming year.

II. STRATEGIC EVALUATION COMMITTEE TASKS AND PROCESS

As detailed in the Strategic Evaluation Chapter of the 1997 HIV Prevention Plan (Chapter 9), the charge of the committee was to provide guidance to the AIDS Office in the implementation of all three levels of the five year strategic evaluation plan, (Prevention Provider Level, Intervention Research Level, and Population-Based Surveillance Level). The 1997 Plan provided clearly defined objectives and tasks which were to be completed during the first year for each of the levels of strategic evaluation. Although responsible for providing guidance for all three levels of the strategic evaluation plan, the bulk of the committee work during 1997 focused on the second level- Intervention Evaluation Research.

Level One- Prevention Provider Level

The prevention provider level of evaluation detailed in the Strategic Evaluation Plan was developed in order to help programs succeed in their efforts to design, implement, and evaluate their programs. The 1997 Plan urges providers to focus on incorporating risk behavior measurement and evaluation into their program designs through the administration of a required Behavioral Risk Assessment (BRA) during the first two years. The expectation outlined in the plan is that that by the third year, providers will be proficient at administering the BRA and will also be conducting annual ongoing impact level evaluation of their programs. In order to achieve these goals, a technical assistance effort for all AIDS Office funded prevention providers is being coordinated by the AIDS Office.

Tasks for Year One (1997)

In 1997, all providers were required to develop, implement, conduct and summarize a Behavioral Risk Assessment with the exception of those conducting only Counseling, Testing, Referral, and Partner Notification (CTRPN) interventions. The BRA includes seven standardized sociodemographic variables, in addition to sexual and injection drug use risk behavior measures. Providers were required to administer the BRA instrument to 100 or 20% of their total client population (whichever was lower). Through the Organizational Development and Evaluation Technical Assistance Project, all providers were offered on-site technical assistance from a team of consultants with expertise in the areas of evaluation and organizational development to assist them with the BRA, in conducting evaluation, and with organizational issues. After completing the BRA, providers were expected to cooperate in a city-wide review of the BRA process organized by the HPPC and the AIDS Office to share their experiences and lessons learned.

Although the Provider Level Evaluation identified tasks to be completed by providers and the AIDS Office, it was the role of the committee to provide guidance to the AIDS Office and the OD/TA Consultants in the implementation of the BRA process. Two tasks were identified at the beginning of the year as the primary responsibility of the Strategic Evaluation Committee.

Task 1-Provider Level Evaluation.

The Strategic Evaluation Committee will provide guidance and oversight to the Organizational Development and Evaluation Technical Assistance Consultants in development and implementation the Behavioral Risk Assessment.

Committee Work and Process

The committee received updates on providers' progress in implementing the Behavioral Risk Assessment. Updates were provided by an AIDS Office staff person and the liaison from the STD Prevention Training Center, both of whom were consultants for the OD/TA project. In addition to the regular updates, committee members were given a six month progress report from all consultants providing technical assistance.

As this was the first year of implementing the BRA, it is logical to expect that issues or questions might arise pertaining to the BRA that were not specifically addressed in the 1997 Plan. When such issues or questions arose, they were identified by the technical assistance team and brought before the committee. The following is a list of issues that were addressed by the Committee:

- *Changes in wording for required BRA variables and measures.* Although all providers are required to include sociodemographic and risk behavior measures in their BRA, changes could be made to the wording to ensure that the instrument was culturally and linguistically appropriate for the client population. The technical assistance team raised the question of how to ensure that if providers changed the wording of required BRA variables, these changes would not alter the meaning of the question. The committee decided that the technical assistance consultants would decide if wording changes were appropriate and ensure that the meaning of the question was not altered. The consultants would then inform the committee of any changes. In addition, the committee requested that the OD/TA consultant team document any wording changes and the reason for the changes.

- *Translation of BRA instruments.* The consultants found that several of the agencies who were translating the BRA into other languages had asked if there were requirements or a standard protocol for translating the BRA instrument. The 1997 Strategic Evaluation Plan did not address translation of required variables and this issue was brought before the committee. The committee decided that the first year of implementation would be considered a pilot year and agencies would be given flexibility and discretion in the translation of the BRA survey. The committee did, however, make recommendations to providers who were translating the BRA. They are: 1) back translate if possible (have someone translate the instrument into the language the survey would be administered and then have a different individual translate the instrument from the administration language back into English); and 2) Have the same individual who translated the instrument participate in the administration of the survey with clients to ensure consistency.

- *Question 12- Optional Sociodemographic variables.* When reviewing the required variables for the BRA instrument, the consultant team found that Question 12 *(Were you educated in another country? If so, specify highest level of schooling)* could yield confusing responses since not all countries calculate "level of schooling" the same way as the United States. The committee decided that Question 12 of the optional sociodemographic variables should be modified to ensure that all responses to this question were comparable. The new wording for the question is:

Were you educated in another country? Yes No
If yes, which country? _____
Specify the highest level of schooling in years. _____*years*

Task 2-Provider Level Evaluation.

When the BRA has been completed, the Committee, in collaboration with the AIDS Office, will organize a community-wide meeting of providers to discuss results from the BRA and the BRA process.

Committee Work and Process

Although this task was assigned in the 1997 Plan as a task to be completed in Year One, it was decided by the AIDS Office, in consultation with OD/TA Project consultants, to delay the community-wide meeting for providers until the second half of 1998. Postponing the meeting until this time would allow for those providers who receive State and General Funding and operate on a fiscal year (July-June) to have completed the BRA before attending the meeting. Over two-thirds (21) of providers are funded through State and General funds.

Level Two- Intervention Research Level

The Intervention Research Level outlines a five-year plan to assess and summarize interventions on various populations with the goal of using this information to enhance the effectiveness of local prevention programs and interventions. The intervention research level consists of three key components: 1) ongoing information gathering about the effectiveness of interventions; 2) identification of gaps in the research designed to evaluate the effectiveness of interventions; and 3) design and implementation of local prevention intervention evaluation research studies to address the identified gaps. The basis of Level Two – Intervention Research will be the compilation and dissemination of the Research Inventory. The Research Inventory is intended to document what research has already been undertaken with specific populations and interventions. This information will be used by the HPPC to identify gaps in evaluation research and to prioritize studies to be conducted in San Francisco. In addition, the information will be summarized in a user-friendly format and made available to the provider community who will

then have the opportunity to critique the literature and discuss the relevance of research findings for the populations they serve in San Francisco.

Tasks for Year One

The 1997 Plan lists four Intervention Level objectives to be completed in the first year of the Five Year Strategic Evaluation Plan. In cooperation with the CDC and other federal funding sources, as well as consulting organizations, the HPPC, and local prevention providers will:

1. Conduct a research inventory, and gather and summarize formative and impact evaluation research studies and findings.

2. Present public summaries of what is working, why and for whom, to the HPPC and the broader prevention provider community to promote group discussions.

3. Guide the HPPC in its effort to identify gaps in research and evaluation of interventions and set priorities for San Francisco evaluation and research efforts.

4. Proactively inform potential funders about local funding needs by developing and distributing a summary of data collection efforts, and sharing locally-defined research priorities with the CDC, NIDA, NIMH, and others.

The above objectives were consolidated into three tasks for the Strategic Evaluation Committee during 1997.

Task 1- Intervention Level Evaluation

The Strategic Evaluation Committee will work with AIDS Office staff and consultants to gather existing effectiveness information about prevention interventions to be included in a Research Inventory and to identify areas (gaps) where further intervention evaluation research is needed.

Committee Work And Process

The Committee devoted the majority of its time and effort throughout the year to working on Level Two- Intervention Research Level of the Strategic Evaluation Plan. After the initial orientation and overview sessions, the committee began discussion on how to gather existing information on intervention evaluation research. This information would be used to assist the committee in identifying gaps in knowledge about the effectiveness of interventions and also would form the basis of the Research Inventory.

The committee set the following criteria for selection of articles to be included in the research inventory and to be used to identify gaps in knowledge:

- Study must be an evaluation of an HIV prevention intervention.
- Only articles published from 1990 to the present would be included. (It was decided that articles published before 1990 would be outdated and severely limited in their applicability to populations in San Francisco.)
- Study must be conducted in the United States.
- Study must include behavioral or biological measures.

A literature search was conducted by the technical support consultants using electronic databases (*Medline* and *PsychLit*) and 88 articles and 9 literature reviews were found which met the inclusion criteria (See Appendix 1 at the end of this chapter for list of articles).

The committee discussed the best way to summarize the information in each article for it to be useful both in developing the Research Inventory and in identifying and prioritizing gaps in intervention research knowledge. A two-step process was developed for summarizing the information from the articles.

First, the technical support team would review the articles to ensure that they met the inclusion criteria and would organize the articles by the intervention types listed in the Strategies and Interventions Chapter of the 1997 Plan (venue-based group outreach, prevention case management, multiple session groups, single session groups, counseling and testing [CTRPN], individual risk reduction counseling, and venue-based group outreach). After reviewing the articles, the committee decided to include two additional intervention types that were not included in the 1997 Plan but had a body of literature evaluating their effectiveness (condom distribution and scientific/technological interventions such as vaccines, post-exposure prophylaxis, and spermicides). Once articles were organized by intervention type, they would be further grouped according to the population they described. The committee discussed at length whether to group articles by Behavioral Risk Population (BRP) within an intervention type, but decided that the grouping for this phase should depend primarily on how researchers targeted their study populations. The committee felt that this process would give an overall picture of what type of research on HIV prevention interventions had been conducted to date and would be a useful starting point for identifying gaps within interventions. (See Appendix 2 for an example).

Once this step was completed and the committee had a general idea of what intervention evaluation studies were published, the committee decided that each article should be summarized in a chart format using the format illustrated below. (See Appendix 3 for an example.)

Format for Summarizing Articles:

Authors;
Title of Article;
Journal, and publication date;

Target Population Location	Intervention Strategy	Outcome Measures	Study Design/ Comparison Group	Follow-up	Outcomes/ Results	Implications	Limitations

Target Population: (Behavioral Risk Population with co-factors)
Summary of Article: (2 or 3 Sentences)

After all the articles evaluating a specific intervention were summarized in the chart format, the committee began the process of identifying gaps in information regarding the effectiveness of the intervention.

Identifying Gaps in Intervention Evaluation Research

The committee spent four meetings developing a process to determine: how gaps should be identified within an intervention (by BRP, by co-factors, or by some other manner); what type of criteria should be applied to identify gaps in a systematic and consistent manner for all interventions.

Stratifying by Populations within an Intervention

A major obstacle encountered by the committee was determining how to stratify by population within an intervention type. The committee discussed separating articles by BRPs, by co-variates (race, ethnicity, geographic location, age), and by co-factors (*e.g.,* homelessness, substance use, mental illness, immigration). The committee wanted to list gaps by BRPs and then by co-factors but it quickly became evident that although San Francisco may utilize BRPs for priority-setting, very little research is conducted according to BRPs. In general, studies relied on more traditional risk group categories such as gay and bisexual men, injection drug users (IDUs), African American females, high school youth, or patients attending a sexually transmitted disease clinic. In addition, the studies did not systematically report all risk behaviors, making it impossible to determine what BRPs the participants belonged to. For example, many studies on gay and bisexual men did not report on the percentage of their sample that were gay and the percent that were bisexual. This made it impossible to determine if the studied intervention was primarily conducted among MSM or if in fact, it was representative of both MSM and MSM/F. Although the committee wanted to maintain the integrity of the 12 BRPs defined by the HPPC, they were not willing to assume that the results of an evaluation study were the same for all BRPs who were included in the study, unless specific risk behavior information was given for the populations in the published article. The committee found that rather than attempting to place studies within the 12 BRPs, it would be more useful to describe the study populations using five categories. The five categories included:

1. Males who have sex with males (MSM), and males who *primarily* have sex with males and *sometimes* have sex with females (MSM/F).
2. Males who have sex with females (MSF), and males who *primarily* have sex with females and *sometimes* have sex with males (MSF/M).
3. Females who have sex with males (FSM), and females who have sex with males and sometimes with females (FSM/F).
4. Females who have sex with females (FSF).
5. Injection drug users (IDUs).

It should be noted that when presented to the larger Council for a concept vote in November, 1997, the Council strongly recommended that the committee describe the gaps using the 12 BRPs. At the request of the Council, the committee agreed to report gaps in the 12 BRP format rather than the five BRP format. However, the committee did find it useful to proceed initially in identification of gaps using the five BRP format.

In addition to stratifying by BRPs within each intervention, the committee decided to further stratify when possible by co-variates (age, race, geographic location and socio-economic status), since these statistics were reported in most of the articles. The committee decided not to stratify further by co-factors (such as homelessness, mental illness, domestic violence, substance use) due to the large number of co-factors that could be included and due to the fact that not all co-factors were systematically reported for all studies.

Criteria to Identify Gaps

To determine areas where studies had not been conducted, the Committee needed to develop criteria which could be applied systematically across all studies and all interventions. Initially, the committee discussed criteria for determining both gaps and priorities for future evaluation research. After further discussion, the Committee developed the following questions to be applied to each study to determine if a gap in information was present:

- When was the study conducted?
- Where was the study conducted?
- What were the important research design issues?
    - Was their random assignment or was there a comparison group?
    - Was the study cross-sectional or longitudinal?
- What was the sample size of the population?
- What was the target population?
- Was there a breakdown by age, race, socio-economic status? If so what was it?
- Were their other important co-factors such as homelessness, mental illness or incarceration that need discussion?
- Was the target population of the study similar to a population in San Francisco or not?
- Can the study's results be applied to the same population in San Francisco?
- Were there any serious methodological flaws in the study?

By applying these questions to all articles, the committee was able to develop a systematic process for comparing evaluation research articles. However, to identify population specific and intervention specific gaps a more comprehensive system had to be developed.

Application of Criteria

The Committee struggled to develop a system to determine whether gaps existed. The committee decided to use a scoring system based on a 5-point scale where 0 indicated a total gap in knowledge; 3 indicated some research done, but still missing information; and 5 indicated no gap in knowledge. It is important to note that in developing this five-point scoring system, the committee was clear in acknowledging that this scoring system was not scientifically valid and would only be used as a tool to help identify gaps. The scores would not be used in the prioritization process.

Once the scoring system was developed, the Committee used the following process for determining gaps:

1. Selection of an intervention type;
2. Review of the summary matrix for each article within the intervention (organized by BRP if possible);
3. Application of the questions discussed above to each article in the intervention type;
4. After review of the articles by BRP, the Committee scored the BRP for the intervention utilizing the scale outlined above;
5. Sub-populations within the BRP were identified if no gap was found in the BRP;
6. Once all BRPs were completed, the committee gave a score of 0-5 to the intervention in general.

This process was initially used on the five BRPs identified by committee. At the request of the Council, the committee used this same process to identify gaps for the 12 BRPs that are listed in the 1997 Plan.

Identification of Gaps

Applying the process outlined above, the Committee identified the following gaps in information about the effectiveness of interventions:

Intervention	Gaps Identified
Condom Distribution	All BRPs
Counseling, Testing, Referral & Partner Notification	• FSF/M-IDU • FSF-IDU • FSF/M • MSF • FSF • MSM-IDU, MSM/F-IDU, MSM, MSM/F, FSM-IDU, MSF-IDU, and FSM under 25 years • Transgender MSM-IDU, MSM/F-IDU, MSM, MSM/F, FSM-IDU, MSF-IDU, and FSM • MSM, MSM/F, and FSM of low socio-economic status • African American and Native American FSM
Individual Risk Reduction Counseling	• All BRPs
Media	• All BRPs
Needle Exchange	• No gaps identified
Prevention Case Management	• All BRPs
Single Session Groups	• All BRPs except for Asian Pacific Islander MSM and MSM/F and African American FSM.
Venue-based Group Outreach	• All BRPs
Venue-based Individual Outreach	• MSM-IDU, MSM/F-IDU, MSM, MSM/F, FSF/M-IDU, FSF-IDU, FSF/M, FSM, MSF, and FSF • Transgender MSF-IDU and FSM-IDU • FSM-IDU and MSF-IDU under 25 years • FSM-IDU and MSF-IDU who are speed users
Scientific and Technological Interventions	• The Committee did not conduct a literature search and identify gaps for these interventions. The research inventory is an ongoing process throughout the five years of the Strategic Evaluation Plan and this intervention will be addressed in the future.

Tasks 2 and 3- Intervention Level Evaluation

Task 2: Once gaps have been identified, the committee, in collaboration with community members, will prioritize intervention evaluation research studies to be conducted in San Francisco and will make this information available to potential funders.

Committee work and process: Due to the amount of time required to summarize the articles and to develop a process for identifying gaps in intervention research evaluation, the committee decided in September to revise its scope of work for 1997. The committee acknowledged the importance of soliciting community input on the prioritization of future intervention research studies and felt that there was not enough time to develop a process for soliciting community input this year. This task will be completed in 1998.

Task 3: The information collected for the research inventory will be summarized and distributed to the broader prevention provider community to promote community discussion on effectiveness of interventions.

Committee work and process: The committee felt that in order to develop a format for the resource inventory that would be useful for providers, they needed to solicit input from the provider community. Given their scope of work for 1997, they decided to postpone this task until 1998 when adequate time could be spent on developing a format for the research inventory. It was also decided that the community discussion on intervention effectiveness would occur once the research inventory was completed and distributed to prevention providers.

Level Three: Population Based Surveillance

While Prevention Provider Level Evaluation is used to measure the impact a program has on its client population and Intervention Research level evaluation is used to evaluate the impact of interventions on various populations, Population-Based Prevention Surveillance aims to evaluate the impact of all prevention efforts at a population level by tracking city-wide trends in indicators of HIV risk or infection over time.

In 1997, the AIDS Office was selected by the CDC to participate in a multi-site national study to develop, field-test, and refine standard HIV prevention indicators to be used by all health jurisdictions in the United States. This grant would allow the AIDS Office, the HPPC and local providers to be proactive partners in the development of *community-wide* evaluation measures and would be a major component of Level 3 evaluation in the five year strategic evaluation plan.

Tasks for Year One- Level Three Evaluation

The 1997 Plan, outlines the following objectives for level three evaluation to be completed during year one:

1. Establish a collaborative team of individuals from other DPH programs, the HPPC, local agencies, local research institutes, and the CDC to accomplish objectives 2-8;

2. Work with its collaborators to develop a standard set of prevention indicators;

3. Identify locally-appropriate supplemental HIV prevention indicators through key informant interviews, focus groups, and consultation with HIV prevention providers and researchers;

4. Identify potential sources of data for the core and supplemental HIV prevention indicators;

5. Collect recent prevention indicator data from identified sources to test their availability, feasibility, validity, and usefulness;

6. Develop a protocol with methodologies for implementing the integration, collection, analysis, interpretation, and use of prevention indicator data in San Francisco;

7. Develop a plan for local and state dissemination of information regarding programmatic usefulness of HIV prevention indicator data; and

8. Prepare and disseminate a report on the intended use of the prevention indicators, the results of the field test, and the feasibility of continued prevention indicator surveillance.

Committee Work And Process

Although objectives were specified for Population-based Prevention Surveillance in the 1997 Plan, the successful completion of these objectives were contingent on the timeline of the CDC for the Prevention Indicators Study. Work on the study during 1997 primarily focused on developing a nation-wide set of standard indicators. This work was directed by the CDC through a series of meetings of experts from various cities throughout the United States. Two committee members with a background in epidemiology were approached to attend these meetings, but could not because of prior commitments. An AIDS Office staff person served on the CDC committee and was responsible for updating the Committee on the progress of the study. In addition, a presentation to the full Council on the study was given in March 1997 by the principal investigator. As this project moves into a new phase during 1998 of identifying indicators of interest in San Francisco, the Committee will become more informed and involved in this level of evaluation.

III. FUTURE TASKS

Based on a review of the Plan's objectives for 1998 and its accomplishments during 1997, the following tasks will need to be completed during 1998:

Level One- Provider Level Evaluation

- In collaboration with the AIDS Office, organize a community-wide meeting of providers to discuss the process and results of the Behavioral Risk Assessment.

- Continue to provide guidance to the AIDS Office and to the OD/TA consultants in the implementation of the BRA.

Level Two- Intervention Level Evaluation

- Continue to develop the research inventory with the inclusion of Scientific and Technological Interventions section and new research which has been recently published.

- Solicit provider input into the development of a user-friendly format for the findings from the research inventory and distribute inventory to providers.

- In collaboration with the AIDS Office, develop a training and technical assistance effort based on the research inventory where providers will have the opportunity to critique the literature and discuss the implications of the findings, as well as their relevance for their populations.

- Prioritize evaluation research studies based on the gaps in information identified in 1997. This prioritization should include a process for soliciting community input.

- Provide potential funders such as the CDC, NIH, NIMH, and NIDA with a list of the prioritized intervention evaluation studies.

Level Three- Population Based Surveillance

- Work with the SeroEpi Branch at the AIDS Office to provide input on the development of local prevention indicators.

Appendices to Chapter 5 – Strategic Evaluation

Appendix 1	Articles Reviewed By Intervention
Appendix 2	Examples of Charts Developed for Overview of Interventions
Appendix 3	Example of Chart Developed Summarizing Articles

Appendix 1

ARTICLES REVIEWED BY INTERVENTION

I. LITERATURE REVIEWS

1. Center for Disease Control and Prevention (1997). HIV Prevention Case Management; Literature Review and Current Practice.

2. Des Jarlais, Hagan, Friedman, Friedmann, Goldberg, et al. (1995). Maintaining Low HIV Seroprevalence in Populations of Injecting Drug Users. *JAMA, 274(15),* 1226-31.

3. Higgins, Galavotti, O'Reilly, Schnell, Moore, Rugg and Johnson (1991). Evidence for the Effects of HIV Antibody Counseling and Testing on Risk Behaviors. *JAMA, 266(17),* 2419-29.

4. Holtgrave, Qualls, Curran, Valdiserri, Guinan, and Parra (1995). An Overview of the Effectiveness and Efficiency of HIV Prevention Programs. *Public Health Reports, 110(2),* 134-46.

5. Kirby, Short, Collins, Rugg, et al. (1994). School-based Programs to Reduce Sexual Risk Behaviors: A Review of Effectiveness. *Public Health Reports 109(3),* 339-60.

6. Oakley, Fullerton and Holland (1995). Behavioral Interventions for HIV/AIDS Prevention. *AIDS, 9,* 479-86.

7. Report to the Committee on Appropriations for the Department of Labor, Health, and Human Services, Education and Related Agencies. (1996). *Needle Exchange Programs in America: Review of Published Studies and On-going Research.*

8. Wingood and DiClemente (1996). HIV Sexual Risk Reduction Interventions for Women: A Review. *American Journal of Preventive Medicine, 12(3),* 209-17.

9. Wolitski, MacGowan, Higgins and Jorgensen (1997). Effects of HIV Counseling and Testing on Risk-Related Practices and Help-Seeking Behavior. *AIDS Education and Prevention, 9, Supplement B,* 52-67.

II. INTERVENTIONS

Condom Distribution

1. Sellers, McGraw, McKinlay (1994). Does the promotion and distribution of condoms increase teen sexual activity? Evidence from an HIV prevention program for Latino youth. *American Journal of Public Health, 84(12),* 1952-9.

Individual Risk Reduction Counseling

1. Kelly, St. Lawrence, et al. (1992). Community AIDS/HIV risk reduction: the effects of endorsements by popular people in three cities. *American Journal of Public Health, 82(11),* 1483-9.

Counseling, Testing, Referral, and Partner Notification

1. Mac Gowan, Brackbrill, Rugg, Swanson, Weinstein, et al. (1997). Sex, drugs, and HIV counseling and testing: a prospective study of behavior change among methadone-maintenance clients in New England. *AIDS, 11(2),* 229-35.

2. Ickovics, Morril, Beren, Walsh, Rodin (1994). Limited Effects Of HIV Counseling And Testing For Women. A Prospective Study Of Behavioral And Psychological Consequences. *JAMA,* 272(6): 443-8.

3. Padian, O'Brien, et al. (1993). Prevention of heterosexual transmission of human immuno-deficiency virus through couples counseling. *Journal of Acquired Immune Deficiency Syndrome, 6(9),* 1043-8.

4. Siegel, Falck, Carlson, Wang (1995). Reducing HIV needle risk behaviors among injection-drug users in the Midwest: an evaluation of the efficacy of standard and enhanced interventions. *AIDS Education and Prevention, 7(4),* 308-19.

Media

1. Soloman, DeJong (1989). Preventing AIDS and other STDs through condom promotion: A patient education intervention. *American Journal of Public Health, 79(4),* 453-8.

Multiple Session Groups

1. Bellis (1993). Reduction of AIDS risk among 41 heroin addicted female street prostitutes: effects of free methadone maintenance. *Journal of Addictive Diseases, 12,* 7-23.

2. Boatler, Knight, Simpson (1994). Assessment of an AIDS intervention program during drug abuse treatment. *Journal of Substance Abuse Treatment, 11(4),* 367-372.

3. Boyer, Barrett, Peterman, Bolan (1997). Sexually transmitted disease and HIV risk in heterosexual adults attending a public STD clinic: evaluation of a randomized controlled behavioral risk-reduction intervention trial. *AIDS, 11(3),* 359-67.

4. Boyer, Shafer, Tschann (1997). Evaluation of a knowledge and cognitive behavioral skills-building intervention to prevent STDs and HIV infection in high school students. *Adolescence, 32,* 25-42.

5. Cohen, Dent, MacKinnon, Hahn (1992). Condoms for men, not women: results of brief promotion programs. *Sexually Transmitted Diseases, 19(5),* 245-51.

6. DiClemente, et al. (1989). Evaluation of a school-based AIDS Education Curricula in San Francisco. *Journal of Sex Research, 26(2),* 188-98.

7. DiClemente, Wingood (1995). A randomized controlled trial of an HIV sexual risk-reduction intervention for young African American women. *Journal of the American Medical Association, 274(16),* 1271-76.

8. Eldridge, St. Lawrence, Little, et al. (1997). Evaluation of an HIV risk reduction intervention for women entering in-patient substance abuse treatment. *AIDS Education and Prevention, 9 Suppl. A,* 62-76.

9. Fisher, Fisher, Misovish, Kimble, Malloy Changing (1996). AIDS risk behaviors: effects of an intervention emphasizing AIDS risk reduction information, motivation, and behavioral skills in a college student population. *Health Psychology, 15(2),* 114-23.

10. Gillmore, Morrison, Richey, et al. (1997). Evaluation of a skill-based intervention to change condom use among high risk sexually active adolescents. *AIDS Education and Prevention, 9, supplement A,* 22-43.

11. Hobfall, Jackson, et al. (1994). Reducing inner-city women's AIDS risk activities: A study of single, pregnant women. *Health Psychology, 13,* 397-403.

12. Howard, McCabe (1990). Helping teenagers postpone sexual involvement. *Family Planning Perspectives, 22(1),* 21-26.

13. Katz, Westerman, Beauchamp, Clay (1996). Effects of AIDS counseling and risk reduction training on the chronic mentally ill. *AIDS Education and Prevention, 8(5),* 457-63.

14. Kelly (1994). Sexually transmitted disease prevention approaches that work. *Sexually Transmitted Diseases, 21(2)(Supplement),* S73-S75.

15. Kelly, Murphy, Washington, et al. (1994). The effects of HIV/AIDS intervention groups for high-risk women in urban clinics. *American Journal of Public Health, 84(12),* 1918-22.

16. Kipke, Boyer, Hein (1993). An evaluation of an AIDS risk reduction education and skill training program. *Journal of Adolescent Health, 14(7),* 533-9.

17. Kirby, Korpi, Adivi, Weissman (1997). An impact evaluation of project SNAPP: an AIDS and pregnancy prevention middle school program. *AIDS Education and Prevention, 9 SupplA,* 44-61.

18. Levy, Perhats, Weeks, Handler, Zhu, Flay (1995). Impact of a school-based AIDS prevention program on risk and protective behavior for newly sexually active students. *Journal of School Health, 65(4),* 145-51.

19. Main, Iverson, McGloin, Banspach, Collins, Rugg, Kolbe (994). Preventing HIV infection among adolescents: evaluation of a school-based education program. *Preventive Medicine, 23(4),* 409-17.

20. Malow, West, Corrigan, Pena, Cunningham (1994). Outcome of psychoeducation for HIV risk reduction. *AIDS Education and Prevention, 6(2),* 113-25.

21. Martin, Butzin, Inciardi (1995). Assessment of a multistage therapeutic community for drug-involved offenders. *Journal of Psychoactive Drugs, 27,* 109-16.

22. O'Hara, Messick, Fictner, Parris (1996). A peer-led AIDS prevention program for students in an alternative school. *Journal of School Health, 66(5),* 176-182.

23. O'Leary, Jemmot, Goodhart, Gebelt (1996). Effects of an institutional AIDS prevention intervention: moderation by gender. *AIDS Education and Prevention, 8(6),* 516-28.

24. Paul, Crosby (1996). Longitudinal changes in alcohol and drug use among men seen at a gay-specific substance abuse treatment agency. *Journal of Alcohol Studies, 57,* 475-85.

25. Peterson, Coates, Catania, et al. (1996). Evaluation of an HIV risk reduction intervention among African American homosexual and bisexual men. *AIDS, 10,* 319-25.

26. Podschun (1993). Teen peer outreach--street work project: HIV prevention education for runaway and homeless youth. *Public Health Reports, 108(2),* 150-5.

27. Reeder, Pryor, and Harsh (1997). Activity and similarity in safer sex workshops led by peer educators. *AIDS Education and Prevention, 9(SupA),* 77-89.

28. Rotheram-Borus, Reid, Rosario (1994). Factors mediating changes in sexual HIV risk behaviors among gay and bisexual male adolescents. *American Journal of Public Health, 84(12),* 1938-46.

29. Rotheram-Borus, Koopman, Haignere (1991). Reducing HIV sexual risk behaviors among runaway adolescents. *Journal of the American Medical Association, 266,* 1237-41.

Schonfeld, O'Hare, Perrin, et al. (1995). A randomized, controlled trial of a school-based, multi-faceted AIDS education program in the elementary grades: the impact on comprehension, knowledge and fears. *Pediatrics, 95(4),* 480-6.

30. Siegal, DiClemente, et al. (1995). Change in junior high school students' AIDS related knowledge, misconceptions, attitudes and HIV preventive behaviors: effects of a school-based intervention. *AIDS Education and Prevention, 7(6),* 534-43.

31. Stanton, Galbraith, Feigelman, and Kaljee (1996). Sexually transmitted diseases, human immunodeficiency virus, and pregnancy prevention. *Archives of Pediatric Adolescent Medicine, 150,* 17-24.

32. St. Lawrence, Brasfield, Jefferson, Alleyne, O'Bannon (1995). Cognitive-behavioral intervention to reduce African American adolescents' risk for HIV infection. *Journal of Consulting and Clinical Psychology, 63(2),* 221-37.

33. Turner, Garrison, Korpita, et al. (1994). Promoting responsible sexual behavior through a college freshman seminar. *AIDS Education and Prevention, 6(3),* 266-277.

34. Walter, Vaughan (1993). AIDS risk reduction among a multiethnic sample of urban high school students. *Journal of the American Medical Association, 270(6),* 725-30.

35. Wexler, Magura, Beardsley, Josepher (1994). ARRIVE: an AIDS education/relapse prevention model for high-risk parolees. *International Journal of the Addictions, 29(3),* 361-86.

Needle Exchange

1. Guydish, Brown, Edginton, et al. (In press). Evaluating impact of needle exchange on young injectors.

2. Guydish, Bucardo, Young, Woods, Grinstead and Clark (1993). Evaluating Needle Exchange: Are there Negative Effects? *AIDS, 7),* 871-76.

3. Guydish, Clark, Garcia, Bucardo (In Press). Evaluation of needle exchange using street based survey methods.

4. Guydish, Clark, Garcia, Downing, Case, Sorenson (1991). Evaluating needle exchange: Do distributed needles come back? *American Journal of Public Health, 81(5),* 1-3.

5. Hagan, Des Jarlais, Purchase, Reid, Friedman (____). Cocaine, AIDS, and intravenous drug use. The Tacoma Syringe Exchange 81-88.

6. Heimer, et al. (1993). Needle exchange decreases HIV prevalence. *American Journal of Medicine, 95,* 214-20.

7. Hurley (1997). Effectiveness of needle exchange programmes for prevention of HIV infection. *Lancet, 349(9068),* 1797.

8. Watters, Estilo, Clark, Lorvick (1994). Syringe and needle exchange as HIV/AIDS prevention for injection drug users. *Journal of the American Medical Association, 271(2),* 115-120.

Prevention Case Management

1. Bryce, Vernon, Brathwaite, et al. (1994). Quality of sexually transmitted disease services in Jamaica: evaluation of a clinic based approach. *Bulletin of the World Health Organization, 72,* 239-47.

2. Centers for Disease Control (1993). HIV prevention through case management of HIV-infected persons--selected sites, United States, 1989-1992. *MMWR, June 18, 1993, No.42,* 448-49, 455-56.

3. Falak et al. (1994). Case management to enhance HIV risk reduction among users of injection drugs and crack cocaine. *Journal of Case Management, 3(4),* 162-66.

4. Schwartz, Dilley, Sorenson (1994). Case management of substance abusers with HIV disease. *Journal of Case Management, 3(4),* 173-78.

Single Session Groups

1. Baker, Kochan, Dixon, Heather, Wodak (1994). Controlled evaluation of a brief intervention for HIV prevention among injecting drug users not in treatment. *AIDS Care, 6,* 559-70.

2. Basen-Engquist (1994). Evaluation for a theory-based HIV prevention intervention for college students. *AIDS Education and Prevention, 6(5),* 412-24.

3. Choi, Lew, Vittinghoff, et al. (1996). The efficacy of brief group counseling in HIV risk reduction among homosexual Asian and Pacific Islander men. *AIDS, 10(1),* 81-7.

4. Jemmott, Jemmott, Fong (1992). Reductions in HIV risk-associated sexual behaviors among African American male adolescents: effects of an AIDS prevention intervention. *American Journal of Public Health, 82,* 372-77.

5. Miller, Booraem, Flowers, Iversen (1990). Changes in knowledge, attitudes, and behavior as a result of a community-based AIDS prevention program. *AIDS Education and Prevention, 2(1),* 12-23.

6. Newman, et al. (1993). An evaluation of a school-based AIDS/HIV education program for young adolescents. *AIDS Education and Prevention, 5(4),* 327-39.

7. O'Donnell, Sandoval, Duran, et al. (1995). Video-based sexually transmitted disease patient education: its impact on condom acquisition. *American Journal of Public Health, 85,* 817-22.

Venue Based Group Outreach

1. Elliot, Gurer, Farrow, Henderson, Cowan (1996). Theater in AIDS Education: a controlled study. *AIDS Care, 8(3),* 321-40.

Venue Based Individual Outreach

1. Anderson, Cheney, Clatts, et al. (1996). HIV risk behavior, street outreach, and condom use in eight high-risk populations. *AIDS Education and Prevention, 8(3),* 191-204.

2. Birkel, Golaszewski, Koman, Singh, et al. (1993). Findings for the Horizontes AIDS education project. The impact of indigenous outreach workers as change agents for IDUs. *Health Education Quarterly, 20(4),* 523-538.

3. Colon, Sahai, Robles, Matos (1995). Effects of a community outreach program in HIV risk behaviors among injection drug users in San Juan, Puerto Rico: an analysis of trends. *AIDS Education and Prevention, 7(3),* 195-209.

4. DiLorenzo, Abramo, Hein, Clare, Dell, Shaffer (1993). The evaluation of targeted outreach in an adolescent HIV/AIDS program. *Journal of Adolescent Health, 14(4),* 301-6.

5. Rietmeijer, Cane, Simons, et al. (1996). Increasing the use of bleach and condoms among IDUs in Denver: outcomes of a targeted, community-level HIV prevention program. *AIDS, 10,* 291-8.

6. Santelli, Celentano, Rozsenich, et al. (1995). Interim outcomes for a community-based program to prevent perinatal HIV transmission. *AIDS Education and Prevention, 7,* 210-20.

7. Weibel, Jimenez, Johnson, et al. (1993). Abstract: Positive Effect on HIV seroconversion of street outreach intervention with IDUs in Chicago--1988-1990. AIDS/HIV/STD World Congress. Berlin.

III. COMBINED INTERVENTIONS

Venue-based Individual Outreach, Multiple Session Groups and Media

1. Kegeles, Hayes, Coates (1996). The Mmpowerment Project: a community level HIV prevention intervention for young gay men. *American Journal of Public Health, 86(8 pt 1),* 1129-36.

Counseling and Testing and Single Session Groups

1. Nyamathi, Flaskerud, Bennet, et al. (1994). Evaluation Of Two AIDS Education Programs For Impoverished Latino Women. *AIDS Education and Prevention, 6,* 296-309.

Multiple and Single Session Groups

1. Ashworth, DuRant, Gaillard, Rountree (1994). An experimental evaluation of an AIDS educational intervention for WIC mothers. *AIDS Education and Prevention, 6(2),* 154-62.

2. Baker, Heather, Wodak, Dixon, Holt (1993). Evaluation of a cognitive-behavioral intervention for HIV prevention among injecting drug users. *AIDS, 7(2),* 247-56.

3. El-Bassel, Schilling (1992). 15-month follow-up of women methadone patients taught skills to reduce heterosexual HIV transmission. *Public Health Reports, 107(5),* 500-4.

Individual Risk Reduction Counseling and Single Session Groups

1. Lurigio (1992). Joining the front line against HIV: an education program for adult probationers. *AIDS Education and Prevention, 4(3),* 205-18.

Individual Risk Reduction Counseling, Multiple Session, and Single Session Groups

1. McCuskar et al. (1992). AIDS education for drug abuser: Evaluation of short term effectiveness. *American Journal of Public Health, 82(4),* 533-540.

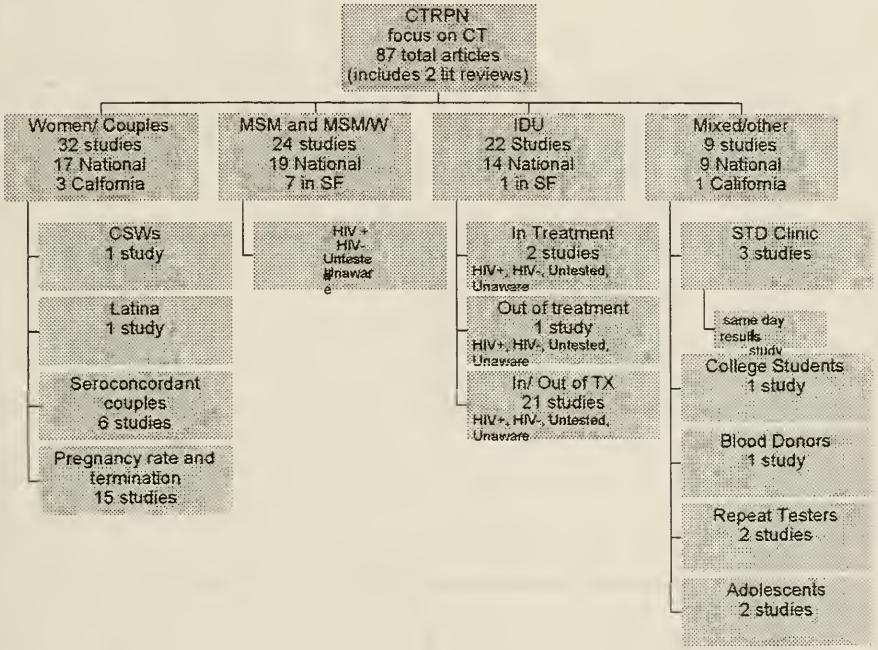
2. McCuskar, et al. (1993). Behavioral outcomes of AIDS educational interventions for drug users in short-term treatment. *American Journal of Public Health, 83(10),* 1463-6.

3. McCusker, Stoddard, et al. (1996). Changes in HIV risk behavior following alternative residential program of drug abuse treatment and AIDS education. *Annals of Epidemiology, 6(21),* 119-25.

Appendix 2

EXAMPLES OF CHARTS DEVELOPED FOR OVERVIEW OF INTERVENTIONS

Counseling, Testing, Referral and Partner Notifcation (CTRPN)



Appendix 3 EXAMPLE OF CHART DEVELOPED SUMMARIZING ARTICLES

Wenger, Greenberg, Hilborne et. al
Annals of Internal Medicine 1992, 117(111): 905-11
Effect of HIV antibody testing and AIDS education on communication about HIV risk and sexual behavior.

Target Population/ Site	Intervention/ Strategy	Outcome Measures	Design/Comparison Group	Follow-up	Outcome/Results	Implications	Limitations
1) Students at a University Health Center 2) Demographics • mean age was 23 years • 72% female • 61% white • 15% Asian • 13% Hispanic • 8% African American • 64% part time jobs • 11% previously tested No significant differences between intervention and control groups Behaviors • mean # of sexual partners prev. month = .8 (median was 1) median lifetime = 4 • 10% had two or more partners past month • 21% had two or more partners past 3 months • 9% not sexually active • 24% had 10 or more partners • median age of first intercourse was 17 years • about 25% reported prior STD • 63% of those sexually active reported vaginal or anal sex with no condom for last partner • Sexual behavior in past month 55% vaginal intercourse no condom (27% w/ condom) 52% oral penile sex no condom (1% w/condom) 4% had anal intercourse with no condom (<1% w/ condom)	CTRPN and SSG	1) HIV knowledge 2) Mental health scale 3) Health worry scale 4) # of partners past month 5) vaginal/anal sex no condom 6) Communication about HIV infection	students randomized to 3 groups: 1) CTRPN+ SSG (n=122) 2) SSG (n=130) 3) control (n=111)	1) 6 months (survey mailed to students) 2) follow-up at 85% only difference between follow-up group and those lost to follow up was age. Those lost to follow-up tended to be younger (21 vs 23 years)	1) Knowledge increase for all (no difference between groups) 2) no change in sexual partners from pre to post for all groups 3) no difference found in vaginal sex w/ no condom, oral sex w/no condom, or anal sex w/no condom between groups or from pre to post. 4) Those in CT + SSG were more likely to increase question asking about HIV testing in partners than those in control or SSG only. Those in SSG did not differ from those in control for question asking. 5) All groups increased questioning partner about number of partners and status regarding IDU. No differences between groups found. 6) Overall those in intervention groups (CT+SSG or SSG only) increase the # of questioning regarding their last partners risk for HIV. An increase of .4 questions compared to .1 question increase for control.	1) Communication with partners improved for all who received SSG (whether or not they had HIV testing) 2) Subjects receiving testing were more likely to assess their partners risk than SSG alone suggesting a dose effect. 3) Behavior did not change	1) baseline levels of sex were low 2) students were volunteers willing to accept testing and return to health clinics at a later date. These subjects comprise only 435 of 2196 approached to participate and may represent a highly motivated group. 3) May not be generalizable to non-student population

Category: youth 18-24 primarily heterosexual in college
Summary: Good article. Was randomized. Did not show behavior change but did show increased communication with sexual partners. Not generalizable to other non- college populations. Students were not that sexually active and drug use questions were not included.

Chapter 6 - HIV Prevalence and Incidence in San Francisco

In 1997, the San Francisco Department of Public Health HIV Seroepidemiology Unit of the AIDS Office held the second Consensus Meeting to estimate HIV prevalence and incidence in San Francisco. (The first was in 1991.) Researchers from around the Bay Area were invited to participate in a modified Delphi process by which estimates are developed, presented to the group, and refined. Although the Council did not conduct this effort, the results produced by this meeting are critical to the Council's planning efforts in San Francisco. Two members of the Council were a part of the Consensus meeting, and the presentations about the results of the Consensus meeting were shared with the full Council. The Assessment Committee used information from the Consensus meeting to revise the priority-setting process (see Chapter 3 of this Addendum). Even though the HPPC itself did not conduct the Consensus meeting, the report of the meeting is included in this Addendum as reference material because the information has been used, and will continue to be used, by the Council in establishing priorities. The report in its entirety is printed below, and copies may be obtained from the San Francisco AIDS Office.

1997 HIV Consensus Report on HIV Prevalence and Incidence in San Francisco

San Francisco Department of Public Health
HIV Seroepidemiology Unit

Prepared by

Kimberly Page Shafer, PhD, MPH
William McFarland, MD, PhD
Mitchell H Katz, MD

1. SUMMARY AND MAIN CONCLUSIONS

The following report summarizes estimates of the prevalence and incidence of HIV infection in San Francisco in 1997. Estimates are based on the expert opinions of researchers, epidemiologists, and services providers attending the 1997 HIV Consensus Meeting convened on May 12, 1997 by the San Francisco Department of Public Health HIV Seroepidemiology Unit (see Appendix A for list of participants and invitees). The meeting consisted of presentations and discussions of recent, empirical data on HIV prevalence and incidence in diverse populations in San Francisco.

The number of persons living with HIV in San Francisco was estimated at 15,249 representing approximately 2% of the entire population. The majority of HIV infections are among men who have sex with men (MSM) (86%), followed by intravenous drug users (IDU) (12%), and heterosexual men and women (3%). Based on these data, an estimated 499 new HIV infections will occur in the next year, with 67% among MSM, and 23% among IDU. Heterosexual men and women will account for 9% of incident infections in 1997. These figures are substantially lower than estimates made at a similar meeting held in 1991 (see Appendix B). Declines in the estimated existing and projected new infections can be attributed to: (1) more accurate information on the populations at risk, (2) decreased rates of new infection, due substantially to successful HIV prevention efforts, and (3) AIDS deaths. Declines in HIV incidence were noted in all transmission categories.

Assessment of the current state of the HIV/AIDS epidemic in San Francisco provides an opportunity to evaluate prevention efforts among populations at risk. Additionally, populations in which HIV prevalence and incidence are currently low point to opportunities to prevent further transmission.

Estimates suggest that HIV prevention efforts in San Francisco have been successful, not only among the highest risk populations (e.g., MSM), but among all populations. Declines in both prevalence and incidence since the 1991 HIV Consensus Meeting follow comprehensive community-based prevention efforts among MSM and intensification of harm-reduction efforts among IDU, such as needle-exchange.

Despite encouraging trends, estimates of HIV prevalence and incidence remain unacceptably high. Estimates presented here underscore the need to maintain current, effective prevention programs. Moreover, to sustain behavior change over long periods of time and to keep pace with evolving therapeutic advances, prevention efforts need to be repeated, updated, and presented through a variety of media and programs. Increasing current resources is critical to prevent further transmission and avert the development of future "waves" of HIV infection among new generations or persistently vulnerable populations. For health care planning purposes, the high prevalence of HIV in San Francisco underlines the tremendous service needs of this population.

The following list highlights key findings from the 1997 HIV Consensus Meeting. A summary of HIV prevalence and incidence by risk populations is presented in Table 1 that follows.

1.1. An estimated 15,249 men, women and children are currently living with HIV infection in San Francisco, representing approximately 2% of the City's population.

1.2. It is estimated that there will be 499 new HIV infections this year (1997).

1.3. The highest proportion of prevalent HIV infections is among men who have sex with men: (86%). It is estimated that 13,135 MSM (including MSM injection drug users) are currently living with HIV infection, and that 336 will become infected this year. It was estimated that 33% of MSM over age 30 are HIV infected, compared to 45% in 1991. HIV prevalence among MSM under 30 years of age was estimated to be 15%.

1.4. An estimated 1,560 male and female injection drug users (IDU) are currently living with HIV infection in San Francisco and 117 are expected to become infected during 1997. (This number does not include MSM-IDU which are presented with the MSM risk group above.)

1.5. An estimated 822 women are living with HIV in San Francisco. Of these, 540 (66%) are believed to be infected due to injection drug use and 282 (34%) due to sexual transmission. An additional 69 women are expected to become infected this year. From 1991 to 1997, HIV incidence estimates declined from 2% to 1% among female IDU, and from 0.03% to 0.01% among female non-IDU.

1.6. The lowest prevalence and incidence of HIV infections in San Francisco are among heterosexual men; an estimated 156 heterosexual, non-IDU men are living with HIV and 16 are expected to acquire HIV infection this year.

1.7. Currently, there are an estimated 66 pediatric cases of HIV infection in San Francisco. It is anticipated that there will be 1 case of HIV infection among infants born in 1997.

1.8. Consistent with national estimates, the risk of transfusion transmission of HIV in San Francisco is on the order of 1 per 300,000 units of blood. Only 1 or no cases of HIV transmission can be attributed to contaminated blood products in San Francisco each year.

Table 1. Estimated HIV incidence and prevalence in San Francisco 1997

Risk Group	Population	Prevalence		Incidence	
		N	%	N	%
Men who have sex with men (MSM)					
MSM Non-IDU	39,000	11,700	30%	283	1.1%
Young (<30)	6,300	945	15%	64	1.2%
Older (30+)	32,700	10,755	33%	219	1.0%
MSM-IDU	4,100	1,435	35%	53	2.0%
Subtotal	43,100	13,135	30.5%	336	1.1%
Heterosexual Male & Female IDUs					
Heterosexual Male	8,500	1,020	12%	76	1.0%
Women	4,500	540	12%	41	1.0%
Subtotal	13,000	1,560	12%	117	1.0%
Other Adult/Adolescents					
Heterosexual Male	259,384	156	0.06%	16	0.006%
Women	281,911	282	0.10%	28	0.01%
Trans/Blood disorders		50		1	
Subtotal	541,295	488		45	
Infants/Children (<13)	105,000	66	0.06%	1	0.001%
Total		**15,249**		**499**	

2. PURPOSE AND GOALS

The specific goals of the 1997 HIV Consensus Meeting were: (1) to assemble a panel of local experts in HIV and AIDS research; (2) to present and discuss recent, local data on HIV prevalence and incidence among diverse risk populations; (3) to record participants' opinions on the current level and future direction of the epidemic; and (4) to arrive at a consensus on the best estimate of HIV prevalence and incidence in San Francisco in 1997. Resulting estimates are intended to guide prevention efforts in the fight against HIV infection.

3. METHODS

A modified Delphi process was used to synthesize the opinions of participants. Participants were given the previous 1991 HIV Consensus Report and other HIV prevalence and incidence estimates prior to the meeting. Presentations of data from completed and on-going studies within each risk population were made on the day of the meeting. Overall estimates of HIV incidence and prevalence for each risk population were arrived at by voting consensus after discussion and deliberation by the group. Discussion and voting were moderated by Dr. George Rutherford. Transcripts of the meeting were reviewed and summarized. A draft report was then circulated to all participants for comment and revision. Figures presented here represent final, revised estimates.

4. DEFINITIONS

The prevalence of HIV was defined as the proportion of the total risk population infected with HIV in 1997. The incidence of HIV was defined as the proportion of the susceptible (uninfected) population acquiring HIV infection in 1997. Voting on prevalence and incidence estimates was restricted to the following risk populations: gay/bisexual men, gay/bisexual male injection drug users, heterosexual male and female injection drug users, heterosexual men, women, transfusion recipients, and children. Empirical data on HIV prevalence and incidence within these risk populations originated from: probability samples of San Francisco neighborhoods; on-going cohort studies of MSM; venue-based samples of MSM, street-sampled IDU and homeless populations; clinic-based unlinked serosurveys; studies of heterosexual partners; street-based samples of youth; and blood donors. A bibliography of studies included in this report is provided in Appendix D.

5. RISK POPULATION SIZE ESTIMATES

Population estimates were based on the 1990 Census. Totals for adults reflect the population under age 65. Totals for infants and children are based on the population aged 13 and under.

MSM population size estimate. Estimates of the number of MSM in San Francisco were largely drawn from the Gay Urban Men's Study (GUMS) (Joe Catania). GUMS uses a combination of data sources (AIDS cases by zip code, commercial mailing lists by zip code, US Census data on male partnered households by census track) to estimate the proportion of MSM households in San Francisco. The GUMS surveyed 14 zip codes that represent areas of highest

MSM density in San Francisco (approximately 85% of MSM households), determined the prevalence of MSM households and the median numbers of MSM per household. This provided an estimated count of MSM in these 14 zip codes and a basis for estimating the number of MSM in the remaining 12 low density zip codes. Compiling all sources and reliability testing suggest that 13.4% of the male population in San Francisco are MSM, with an absolute range of 34,739 to 44,500. The estimate of 43,100 as the MSM population size for the 1997 Consensus Meeting was arrived at by the group after consideration of the following points: (1) agreement was reached that the GUMS range was plausible; (2) 39,000 of the total were estimated to be non-IDU MSM; (3) MSM-IDU were estimated to number 4,100 individuals. Further stratification by age groups estimated that: (1) 6,300 (16%) of MSM were under 30 years of age; and (2) that 33,000 (84%) were 30 years and older. Although these estimates may be the most reliable to date, limitations were noted: (1) the GUMS estimates are point estimates and do not reflect short-term residence or migration; (2) younger MSM are more likely to be transient or recent residents and therefore more likely to be under-counted; (3) the GUMS study would under-count MSM who were not sexually active since adolescence or who were closeted; (4) MSM in multi-residence or non-residence situations may be under-counted; and (5) the GUMS may under-count ethnic minorities, especially closeted ones. In spite of these limitations, the GUMS represents the most recent, scientifically rigorous attempt to estimate the MSM population in San Francisco.

IDU population size estimate. The number of IDU in San Francisco was estimated at 13,000 (John Newmeyer). This number does not include the number of MSM-IDU (N=4,100), which were included in the MSM population size estimate. The number of male IDU was estimated as 8,500; the number of female IDU was estimated as 4,500. The estimates of the number of IDU were based on data from several sources and included the following considerations: (1) the lower boundary of the population size was based on the number of IDU using needle exchange programs, 10,000; (2) the number in treatment representing approximately 1/3 of the total IDU population; (3) there may be under-counted cases of young, new IDU in the city; and (4) there is uncertainty as to whether increases in new IDU equal losses due to cessation and death.

Other population estimates. Estimates of the number of other adults and adolescents were obtained by subtracting the number of MSM and IDU from total population estimates of adults under age 65 from the 1990 Census. The estimated numbers of infants and children (13 years) were also based on the 1990 Census.

6. HIV PREVALENCE AND INCIDENCE ESTIMATES BY RISK POPULATIONS

MSM. The most comprehensive data on prevalence and incidence of HIV infection were available for MSM, the population which continues to be the most severely affected by the epidemic in San Francisco.

HIV prevalence and incidence data were presented from the San Francisco Young Men's Health Study (SFYMHS) and the Multicultural Men's Health Study (GUMS) a subset of the GUMS (Dennis Osmond). Estimates are presented in Table 2. HIV prevalence ranged from 9% among 18 to 29 year-olds to 38% among 40 to 59 year-olds in the GUMS. Prevalence data from the

GUMS (N=783) were based on self-reported HIV status and results from a home HIV test. In the SFYMHS, HIV prevalence ranged from 12% to 18% among 18 to 29 year olds depending on the sample design. SFYMHS follows a cohort of MSM (N=428) recruited in 1992 from a population-based sample of single men age 29 and younger. HIV incidence in this cohort is 1.6% per year. Additionally, the SFYMHS recruited a referral sample (n=565) of other MSM whose observed HIV incidence is 1.2% per year. In the SFYMHS, prevalence and incidence are measured by both serology and self-report. Concordance between self-reported results and the home HIV test kit were high. Differences in HIV prevalence between the SFYMHS and GUMS may be attributed to: (1) the SFYMHS sample was concentrated in the Castro, while the GUMS extended to neighborhoods with a somewhat lower MSM population density; and (2) GUMS prevalence was largely based on self-report, which may be an underestimate of true HIV prevalence.

A presentation was made on statistically modeling HIV incidence based on the SFYMHS data (Sally Blower). These analyses demonstrate that some older seropositive men have been an important source of HIV infection for some of the young gay men. HIV incidence was estimated to be 1% per year among 18 to 24 year old MSMs, and 2% per year among 25 to 29 year old MSMs (Table 2). Analyses of the SFYMHS data have led to the identification of sexual partner selection as a new risk factor for HIV acquisition.

Recent HIV incidence data were also available from two cohort studies of high-risk MSM conducted by the Department of Public Health (Jumpstart and HIVNET) (Susan Buchbinder). Both projects recruited high-risk MSM for HIV vaccine preparedness studies and prevention interventions. Many subjects participated in both cohorts. HIV incidence in Jumpstart was 2.7% per year overall, 2.9% per year among men under 25 years, and 2.6% per year for men over 25 years of age. HIV incidence was highest among Latino and African American MSM, 4.2% and 3.5% per year.

Table 2. Age stratified prevalence and incidence rates in MSM from two population-based samples in San Francisco.

Study	Prevalence (%)	Incidence (%/yr.)
SFYMHS (18-29 yrs)*	18	1.6
SFYMHS (18-29 yrs)#	12	1.2
GUMS (overall)	25	
18-29	9	
30-39	23	
40-59	38	
SFYHMS (22-33 yrs)*	15	
GUMS (22-33 yrs)	10	
SFYHMS (18-24 yrs)*		1.0
SFYHMS (25-29 yrs)*		2.0

* population-based sample; # snowball-referral sample

Among white MSM, HIV incidence was 2.4% per year. Overall HIV incidence in HIVNET was 2.4% per year. Unlike Jumpstart, HIV incidence was lower among younger men (<25 years), 1.9% per year, compared to older men, 2.5% per year. In HIVNET, African-American MSM had the highest incidence of HIV (4.7% per year), followed by Latinos (2.5% per year) and whites (2.1%). The Jumpstart and HIVNET HIV incidence figures may be higher than the overall MSM population in San Francisco due to the effort to recruit higher risk MSM, including STD patients.

Sentinel surveillance data from a variety of studies conducted by the HIV Seroepidemiolgy Unit were also summarized (Tim Kellogg). HIV prevalence from the Young Men's Study (YMS), a venue-based sample of MSM age 17 to 22 years, was 10% in 1992/93 and 7.8% in 1995/96. HIV prevalence among MSM clients of the municipal STD clinic has declined from 50.1% in 1989 to 24.4% in 1996. Among MSM seeking repeat anonymous HIV testing, HIV incidence was 1.6% per year in 1996.

Another method to estimate HIV prevalence and incidence among MSM used back-calculation of AIDS case data (John Newmeyer). By this method, HIV prevalence among MSM was estimated to be 26% in 1997. Further it was estimated that this prevalence had been declining by two points per year until 1996, because HIV positive men were dying and being replaced by HIV-negative men who migrated in or "came out." Newmeyer suggests that this decline slowed in 1997 because of the efficacy of "cocktail" therapies among HIV positive men.

After discussion of the above data, the following consensus was reached: HIV prevalence among MSM overall is 30% and the estimates ranged from 24%-38%. HIV incidence is estimated to be 1.1% per year overall and to range from between 0.5 and 1.5% per year. HIV prevalence among MSM under age 30 is estimated to be 15% and to range from 9% to 18%. HIV incidence among

MSM under 30 is believed to be 1.2% per year, ranging from 1 to 2% per year. Among MSM over 30 years of age, prevalence is estimated to be 33%, ranging from 23% to 38%. HIV incidence is believed to be slightly lower in older compared to younger MSM, at 1.0% per year. The highest HIV prevalence and incidence are believed to be among MSM who inject drugs: 35% and 2.0% per year, respectively. Prevalence among MSM-IDU is estimated to range from 14% to 49%.

IDU. Data from the Urban Health Study (U HS) comprised a sample of street-recruited IDU in San Francisco. In several years of cross-sectional samples, HIV prevalence peaked at 16% in 1993, dropping to 10.7% in 1996. Table 3 shows HIV prevalence by gender and sexual orientation among IDU in the Urban Health Study. Caution was advised in interpretation of sexual risk behavior groups in this population as up to 33% of IDU report no sexual activity.

Table 3. HIV prevalence in a street-based sample of IDU in San Francisco from the Urban Health Study.

Urban Health Study Population	Prevalence (%)
Overall (male and female)	12.7
Female heterosexual	10.7
Female bisexual	17.4
Female lesbian	20.0
Male heterosexual	12.4
Male bisexual	10.7
Male homosexual	28.9

Other data on IDU were obtained from a random sampling strategy at street locations (Joe Guydish). Based on comparisons with data available from Prevention Point Needle Exchange Program (NEP), the random sample is considered to be representative of NEP clientele. HIV prevalence among NEP clients was 14% in 1992, and 17% in 1993.

Additional data of HIV prevalence among IDU in treatment were made available by the HIV Seroepidemiology Unit. HIV prevalence in unlinked sentinel surveillance studies at a drug treatment center in 1996 was 9.9% among men and 10.9% among women (Table 4).

Consensus was reached that the prevalence of HIV among male and female IDU is 12%. While no empirical data were available regarding HIV incidence among IDU in San Francisco, an estimate of 1.0% per year would best account for the UHS finding of neither an increasing nor a decreasing trend in IDU prevalence, in spite of removal of HIV positive IDU through death.

Table 4. HIV Prevalence among IDUs entering methadone treatment (Tx) in San Francisco in 1996.

IDU population entering methadone Tx	Prevalence (%)
African-American (Males & Females)	22.4
Asian/Pacific Islander (Males & Females)	9.1
Latino (Males & Females)	13.0
White (Males & Females)	5.8
Males overall	9.9
Females overall	10.9

Heterosexuals. Estimates of the HIV infection rates among other adults/adolescents populations were based on data from several sources, including: the Survey of Childbearing Women (Tim Kellogg); screening of military recruits; unlinked surveys of adolescents entering Youth Guidance Center (Tim Kellogg); heterosexuals attending the municipal STD clinic (Charlotte Kent); and the Multicultural Study of Crack Cocaine and HIV Infection conducted as a part of the AMEN study in multiethnic neighborhoods (Carl Word).

The State-conducted Survey of Childbearing Women has monitored HIV prevalence by unlinked testing of newborn infants over a 3-month sampling period from 1991 to 1995. HIV prevalence among women of childbearing age in San Francisco was 0.36% in 1991, 0.20% in 1992, 0.21% in 1993 and 0.21% in 1994, and 0.28% in 1995.

HIV prevalence among female attendees of the STD clinic has been stable for several years at 1.1% in 1993, 0.8% in 1994, and 1.5% in 1995. HIV prevalence among heterosexual male attendees of the STD clinic has shown a downward trend over the same period, from 2.3% in 1993 to 1.5% in 1995.

Preliminary data from the 1997 population-based study of women in low-income neighborhoods (YWS) indicates an HIV prevalence of 0.36% for women between the ages of 18 and 29 years. The estimate is similar to the HIV prevalence among women in the 1989 population-based AMEN study, 0.4%.

Low prevalence of HIV continue to be reported among military recruits, 50% of whom are typically under 19 years old. Among 1,969 San Franciscan recruits tested between 1991 and 1995, five were HIV positive (0.25%). Of note, over 33% of the military recruit population is Asian/Pacific Islander, representing the most substantial sample available of this ethnic population.

The Multicultural Study of Crack Cocaine and HIV Infection was a subset of the AMEN study and investigated HIV prevalence in the Bayview/Hunters Point area. It was designed to sample

400 crack users and 400 non-crack users. Among male crack users, HIV prevalence was 5.6%, and 2.0% among female crack users. In follow-up samples there were no incident HIV infections; however, rapid spread of HIV infection among crack users in Miami and New York could portend the same for San Francisco. Discussion ensued regarding other markers for HIV infection among this primarily African-American population, including declining STD rates, and lower overall HIV prevalence among the heterosexual population in San Francisco compared to Miami and New York.

Consensus was reached that overall HIV prevalence among the female non-IDU heterosexual population was between 0.067% and 0.13% (0.10%), or approximately 200-400 women in San Francisco. The figure includes consideration of the above points plus the number of female (non-IDU) AIDS cases currently living (N=121). HIV incidence was estimated to be 0.01% per year, or 1 new HIV infection for every 10,000 women. Among heterosexual males (non-IDU), HIV prevalence was estimated as 0.06% (150 currently infected in San Francisco), and incidence as 0.006% per year (16 new infections per year). The range for HIV prevalence among non-IDU heterosexual men is thought to be 0.008% to 0.1%, or 20 to 250 HIV infections.

Infants and children. Pediatric HIV surveillance in Northern California indicates that there are 25 known, living cases in San Francisco (David Hill). The figure may be under-estimated due to four considerations: (1) surveillance can lag by 6 months, (2) one-third of infants born to HIV-positive mothers are lost to follow-up before infection status can be confirmed, (3) many pediatric HIV cases have "unknown" residence status, and (4) families with HIV-infected children often move to San Francisco for care after residence status is recorded elsewhere. The consensus estimate for the number of infants and children living with HIV was therefore set at 66. Approximately 10 HIV-positive pregnant women deliver in San Francisco each year. Considering the known rate of mother to child transmission combined with the availability of treatment to interrupt transmission, it is estimated that one infant born in San Francisco each year will become HIV-infected out of approximately 8,000 to 9,000 births.

Transfusion transmission. With universal screening of donated blood for HIV antibody and antigen, deferral of donors at risk, and other technologies available to eliminate contamination in blood products, the risk of HIV infection through transfusion is on the order of 1 per 300,000. While it is theoretically possible for San Franciscans to acquire HIV from blood products (due to the window period, false-negatives, and human error), the risk of transmission from transfusion is currently small in absolute and relative terms. The estimate of 1 infection due to blood products each year is offered to acknowledge the theoretical possibility. For simplicity, the present report includes existing HIV infections due to blood transfusion in the general heterosexual population.

Special populations: the homeless and marginally housed. A probability-based sample of homeless and indigent persons drawn from shelters, free meal programs, and low-cost residential hotels is currently underway in San Francisco in the Treatment Research on AIDS and Tuberculosis study (TREAT) (David Bangsberg, Marjorie Robertson). The study is ongoing and includes assessment of HIV and TB prevalence. Subjects include "literally homeless" adults (N = 530), and "marginally housed" adults (N=396). Literally homeless were defined as having spent

the night prior to their interview on the street or in a shelter. The population size for the literally homeless ranges from 6,000 to 8,000 in San Francisco. The marginally housed were sampled from low-income hotels (<$400/month or $15/day) in the Mission, Tenderloin and South of Market neighborhoods. The marginally housed population was estimated at 6,250. Both target populations include a large number of IDU, MSM, and persons engaging in commercial sex work.

Table 5 summarizes preliminary HIV prevalence estimates in the TREAT study population. Among the literally homeless, HIV prevalence ranges from 2% among non-IDU women to 31% among MSM-IDU. A similar pattern is observed among the marginally housed, with HIV prevalence ranging from 4% among non-IDU heterosexuals to 49% among MSM-IDU. Overall HIV prevalence was estimated as 7.1% among the literally homeless and 12% among the marginally housed.

Table 5. Estimated HIV Prevalence in homeless and marginally housed adults in the TREAT study in San Francisco in 1997

	Seroprevalence (%)	
Risk Group	**Homeless (N=530)**	**Marginally Housed (N=396)**
MSM Men		
Non-IDU	24	41
IDU	31	49
Injection Drug Users (ever)		
Heterosexual Male	5	8
Female	3	4
Other Adult (non-IDU)		
Heterosexual Male	4	4
Female	2	4

7. HIV PREVALENCE ESTIMATES BY RACE/ETHNICITY

Table 6 provides the race/ethnicity stratification of HIV prevalence and incidence in San Francisco in 1997. Estimates are based on many of the same sources of information as described above, HIV sentinel surveillance, targeted prevalence studies, AIDS surveillance, and back calculation from AIDS case data. The majority of persons currently living with HIV infection are white (70%), most of whom are MSM men. Persons of color make up the remaining 30% of current HIV infections, largely injection drug users, women, infants and children. In 1992, it was estimated that 38.8% of HIV infections were among non-white racial/ethnic groups. AIDS surveillance shows that among AIDS cases currently alive, 29.7% are among persons of color.

Figure 1 shows distributions of HIV infection and AIDS by race/ethnicity. Included are the 1997 estimate of the distribution of prevalent infections, the distribution of AIDS cases currently alive, the 1995 distribution of HIV infections from STD patients at the San Francisco City Clinic, and John Newmeyer's estimate of the distribution of all incident HIV infections in San Francisco.

Table 6. Estimates of the number of persons infected with HIV in San Francisco by Race/Ethnicity.

Distribution of HIV Infections											
Risk Group	**White**		**Afr-American**		**Latino**		**Asian/PI**		**Other**		**Total HIV**
	No.	%	No.	%	No.	%	No.	%	No.	%	No.
MSM											
Non-IDU	8919	76.2	682	5.8	1188	10.2	574	4.9	336	2.9	11,700
Young (<30)	639	67.6	90	9.5	113	12.0	90	9.5	13	1.4	945
Older (30+)	8280	77.0	592	5.5	1075	10.0	484	4.5	323	3.0	10,755
IDU	789	55.0	330	23.0	244	17.0	50	3.5	22	15.0	1,435
Subtotal	9708	73.9	1012	7.7	1432	10.9	624	4.8	358	2.8	13,135
Heterosexual Male & Female IDU											
Het. Male	471	46.2	350	34.3	122	12.0	47	4.6	30	2.9	1,020
Female	161	29.8	243	45.0	65	12.0	36	6.6	36	6.6	540
Subtotal	632	40.5	593	38.0	187	12.0	83	5.3	66	4.2	1,560
Other Adult/Adol											
Het. Male	62	40.0	53	34.0	28	18.0	10	6.5	2	1.5	156
Female	96	34.0	155	55.0	14	5.0	3	1.0	14	5.0	282
Trans/Blood dis.	27	54.0	8	16.0	8	16.0	8	16.0	0	0.0	50
Subtotal	185	37.9	216	44.3	50	10.2	21	4.3	16	3.3	488
Total Adult HIV inf.	**10,525**	**69.3**	**1821**	**12.0**	**1669**	**11.0**	**728**	**4.8**	**440**	**2.9**	**15,183**
Adult HIV Seroprev.		**3.6**		**3.4**		**2.4**		**0.5**		**1.3**	**2.5**
Infants/Children	28	42.5	23	35.0	8	12.5	3	5.0	3	5.0	66
Total HIV Infections	**10,553**	**69.2**	**1844**	**12.1**	**1677**	**11.0**	**731**	**4.8**	**443**	**2.9**	**15,249**
Total HIV Seroprev.		**3.3**		**2.7**		**1.9**		**0.4**		**1.0**	**2.2**
Total # of AIDS Cases Alive	**5,317**	**70.3**	**1,073**	**14.2**	**908**	**12.0**	**232**	**3.1**	**38**	**0.5**	**7,568**

8. CONCLUSION

Declines in HIV seroincidence rates among MSM were first observed in several cohort studies after 1984, concurrent with decreases in high-risk sexual behaviors. Since 1992 AIDS incidence and mortality have declined among MSM, the first indications of effective control of the epidemic in San Francisco. Among all other risk groups, AIDS incidence has declined since 1993, and mortality since 1995 (Appendix A). HIV prevention in the forms of community mobilization, public health efforts, government planning, advocacy groups, and scientific activities have contributed to this success (M.H. Katz).

The 1997 Consensus Conference on HIV offers a comprehensive look at the continuing successes and challenges of HIV prevention in San Francisco. However, some limitations should be pointed out. Estimates for MSM are likely to be better than any other risk group largely because of the methodologies employed and by the large number of studies conducted in this group. Because of this, we have more confidence in these estimates than estimates for other risk groups. Data for other risk groups are less available, and the numbers may be less conclusive. HIV seroincidence among IDUs, for instance, has not been comprehensively documented since the 1985-1990 period (A. Moss). New data on HIV infection in the homeless offers compelling evidence that the epidemic continues to move into marginalized populations with devastating effects. Data must be continually collected and assessed in all populations at risk to effectively monitor the epidemic and document trends.

HIV infection continues to decline in San Francisco. The decline is due, in large part, to the significant declines of HIV infection rates among MSM. Although similar declines are not as large among other risk groups, numerous indicators (e.g., AIDS incidence, declines since the 1991 Consensus Meeting Report) point in the same direction. Despite these declines, HIV prevalence and incidence rates remain unacceptably high. Over 15 years into the HIV epidemic, the results of this meeting support a main premise: HIV infection prevention requires sustained, extensive, collaborative and targeted efforts by multiple allies committed to long term change.

ACKNOWLEDGMENTS

The San Francisco Department of Public Health wishes to thank all the researchers who participated in this meeting, especially those who took the time to present their data and for providing their feedback on the Report. We also thank Al Abramowitz, Community Substance Abuse Services SFDPH; Kristen Clements, Epidemiology and Evaluation Unit, SFDPH; Charlotte Kent, STD Control, SFDPH; Jeff Klausner, STD Control, SFDPH; Susan Samson, Irwin Memorial Blood Centers; and Laura Thomas, San Francisco AIDS Foundation for their participation. We acknowledge the logistic support and helpful assistance of Giuliano Nieri, Sandy Schwartz, Kurt Scheer, and Susan Black. Finally we wish to thank George Rutherford of the University of California at Berkeley School of Public Health for moderating the meeting.

APPENDICES TO CHAPTER 6

Figure 1: Distribution of AIDS/HIV infection by Race/Ethnicity.

A. Summary of Decline in AIDS Deaths by Sex, Race and Risk.

B. 1991 Consensus Meeting Summary Tables. (Include overall and race/ethnicity).

C. 1997 Consensus Meeting Participants and Invitees.

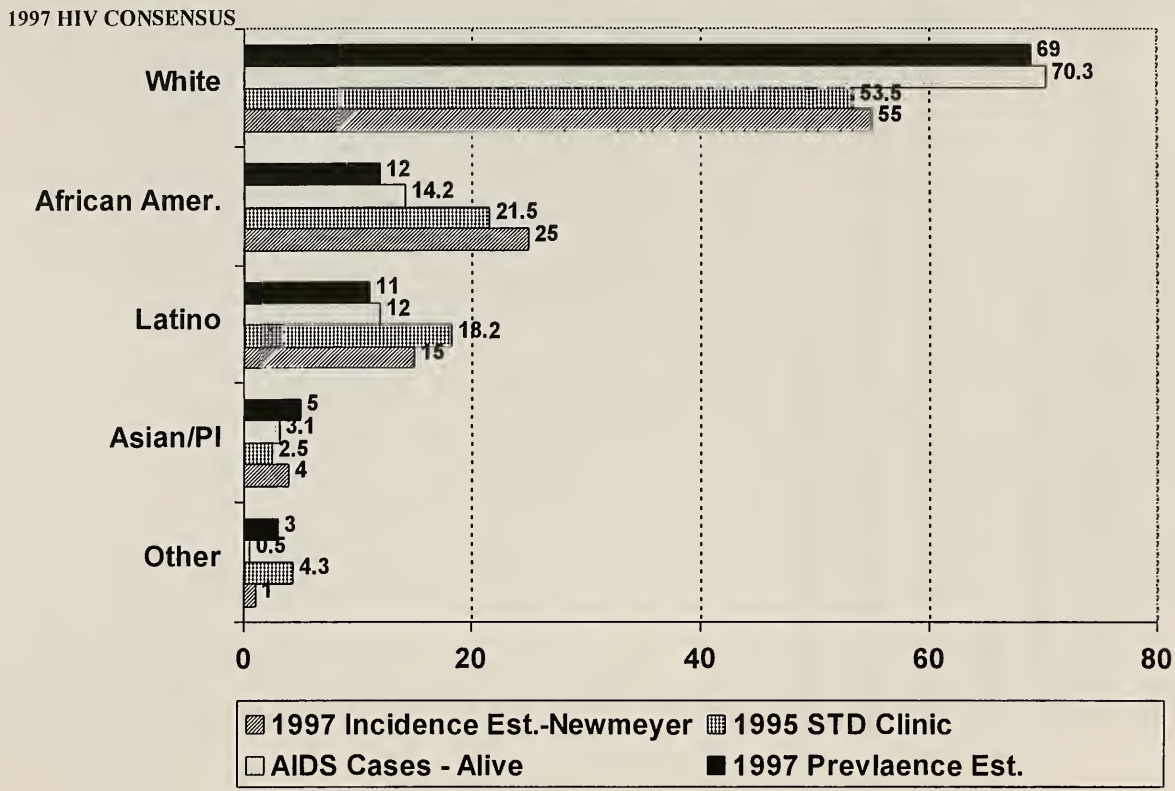
D. References

E. HIV Estimates for the San Francisco Metropolitan Area by Scott Holmberg.

F. HIV Estimates for the San Francisco Metropolitan Area by HRSA.

G. Meeting Agenda and List of Presentations.

Figure 1:
DISTRIBUTION OF AIDS/HIV INFECTION BY RACE/ETHNICITY



Appendix A
SUMMARY OF DECLINE IN AIDS DEATHS BY SEX, RACE, AND RISK

Trends in AIDS deaths follow the trends in AIDS cases. The number of AIDS cases diagnosed in San Francisco has declined since 1993. The decline in AIDS deaths was first observed in 1995. People of color, women, and injection drug users account for an increasing percentage among persons newly diagnosed with AIDS. Similar trends are observed among persons who have died with AIDS.

The number of AIDS deaths that occurred each year has continued to decline since 1995. There was a 21% decrease from 1994 to 1995, and a 36% decrease from 1995 to 1996. The decline in AIDS deaths in 1996 occurred mostly among whites (38%) and Asians (45%), and less among African Americans (26%) and Latinos (25%). Women accounted for 9% of decrease in 1996 compared with 36% of decrease among men. All risk groups appeared to have a substantial drop in AIDS deaths except injection drug users in whom deaths declined by only 2% in 1996.

Number of AIDS Deaths and Percent Change during 1994 and 1996

	1994	1995	[% change 94-95]	1996	[% change 95-96]
Sex					
Male	1741	1374	[-21%]	873	[-36%]
Female	67	46	[-31%]	42	[-9%]
Race					
White	1307	1039	[-21%]	643	[-38%]
African American	231	170	[-26%]	125	[-26%]
Latino	195	151	[-23%]	113	[-25%]
Asian	62	51	[-18%]	28	[-45%]
Native American	13	9	[-31%]	6	[-33%]
Risk					
MSM	1472	1107	[-25%]	707	[-36%]
IDU	124	103	[-17%]	101	[-2%]
MSM and IDU	145	167	[+15%]	85	[-49%]
Transfusion/Hemophilia	21	13	[-38%]	9	[-31%]
Heterosexual	25	16	[-36%]	6	[-63%]
Other/Unknown	21	14	[-33%]	7	[-50%]
Total	**1808**	**1420**	**[-21%]**	**915**	**[-36%]**

Appendix B

ESTIMATES OF THE NUMBER OF PERSONS INFECTED WITH HIV IN SAN FRANCISCO BY RACE/ETHNICITY

San Francisco Department of Public Health AIDS Office

Risk Group	White	African American	Latino	Asian/ Pacific Is.	Native American	Other	Total
Gay & Bisexual Men							
Non-IDUs	14,587	3,028	3,355	2,027	161	NA	23,158
IDUs	1,223	210	234	142	11	NA	1,820
Subtotal	15,810	3,238	3,589	2,169	172	NA	24,978
Injection Drug Users							
Het. Men	418	637	103	21	8	2	1,188
Women	158	290	44	6	3	1	502
Subtotal	576	927	147	27	11	3	1,690
Other Adults/Adol							
Het. Men	120	44	33	38	1	2	239
Women	376	139	72	46	4	2	639
Subtotal	496	183	105	84	6	4	878
Infants & Children	29	29	16	8	1	0	83
Total	16,910	4,378	3,857	2,288	189	7	27,629
HIV Seroprevalence	5.0%	5.7%	3.8%	1.1%	7.2%	0.5%	3.8%
Living AIDS Cases (as of March 31, 1993)	3,911	584	531	109	20	NA	5,155
RATIO (HIV Infection to AIDS Cases)	4.32	7.50	7.26	20.99	9.47	NA	5.36

Appendix C
1997 CONSENSUS MEETING CONTACT LIST

Al Abramowitz, CSAS, SFDPH
David Bangberg, SFGH, CAPS, UCSF
Benjamin Bowser, Dept. of Sociology, Cal State Hayward
Susan Buchbinder, Research Section, CHS, SFDPH
Joe Catania, Center For AIDS Prevention Studies, UCSF
Kristen Clements, Epidemiology & Evaluation Unit, CHS, SFDPH
Joe Guydish, UCSF Inst. for Health Policy Studies
Nancy Hessol, UCSF Women's Clinic
Mitch Katz, Director, Epidemiology, Disease Control and AIDS, CHS, SFDPH
Valerie Kegebein, Planning & Policy Unit, CHS, SFDPH
Tim Kellogg, Seroepidemiology and Surveillance Branch, CHS, SFDPH
Charlette Kent, Project Respect - City Clinic, SFGH
Peter Kerndt, LADPH, HIV Epi Program
Jeff Klausner, STD Division, City Clinic, SFDPH
Bob Kohn, City Clinic, STD Division, SFDPH
Alex Kral, Urban Health Study, UCSF
Willi McFarland, Seroepidemiology and Surveillance Branch, CHS, SFDPH
John Newmeyer, HAFMC
Norm Nickens, Director's Office, AIDS Office, CHS, SFDPH
Giuliano Nieri, Seroepidemiology and Surveillance Branch, CHS, SFDPH
Dennis Osmond, Center For AIDS Prevention Studies, UCSF
Nancy Padian, UCSF, UC Berkeley
Marjorie Robertson, UCSF Dept. of Epi/SFGH
George Rutherford, UC Berkeley School of Public Health
Susan Samson, Irwin Memorial Blood Bank
Kimberly Page Shafer, Seroepidemiology and Surveillance Branch, CHS, SFDPH, Center for AIDS Prevention Studies, UCSF
Janet Shalwitz, Bureau of Children, Youth & Families
Warren Winkelstein, UC Berkeley, School of Public Health
Carl Word, Bayview Foundation
Janet Heitgerd, CDC - Division of HIV/AIDS Prevention
Deborah Rugg, CDC - Division of HIVIAIDS Prevention
Sally Blower, Center For AIDS Prevention Studies, UCSF
John Conley, San Mateo County AIDS Program
Krisia Linden, Center For AIDS Prevention Studies, UCSF
Laura Thomas, SF AIDS Foundation
Karen Wuopio, Marin Health Department

Appendix D

REFERENCES

1. Winkelstein, W. All Epidemics are local. Presentation

   Winkeistein W, Lyman DM, Padian N. Sexual Practice and Risk of Infection by the Human Immunodeticiency Virus. *JAMA* 1987; 257:321-325

   Fullilove MT, et al. Risk for AIDS in multiethnic neighborhoods in San Francisco, California. *West J Med* 1992; 157:32-40

2. McFarland W. HIV Prevalence and Incidence Estimates for San Francisco. Presentation

   HIV Incidence and Prevalence in San Francisco in 1992: Summary Report from an HIV Consensus Meeting, SFDPH AIDS Office, Feb.12, 1992,1-3

   Holmberg SD. The estimated prevalence and incidence of HIV in 96 large US metropolitan areas. *Am J Public Health* 1995; 85:642-654.

3. Kellogg, T. Overview of HIV Sentinel Surveillance in San Francisco, 1991-Present.

   HIV Seroprevalence Report. San Francisco Department of Public Health AIDS Office. November, 1996. Vol 7, No.2

   HIV Incidence and Prevalence in San Francisco on 1992: Summary Report from and HIV Consensus Meeting, SFDPH AIDS Office, Feb.12, 1992,1-3

4. John Newmeyer Back Calculation as a Method for Estimating HIV Prevalence and Incidence. Presentation

   Newmeyer JA. Successful HIV/AIDS Modeling in San Francisco: Accurately Estimating Heterosexual Injecting Drug User Population Size and AIDS Cases. *Modeling the AIDS Epidemic: Planning Policy and Prediction*, edited by E. H. Kaplan and M. L. Brandeau, Raven Press, Ltd., N.Y, 1994

   Newmeyer JA. Creating a Model of the AIDS Epidemic Among San Francisco IVDUs, *MidCity Numbers*, MidCity Consortium to Combat AIDS, San Francisco, 08k/01/88, 1-4

   Newmeyer JA, A Spreadsheet for AIDS: Estimating Heterosexual Injection Drug User Population Size from AIDS Statistics in San Francisco, *Journal of Psychoactive Drugs*, 1990; Volume 22, 343-349

5. Marjorie Robertson and David Bangsberg. HIV Prevalence in the Homeless and Marginally Housed. Presentation

   Robertson M, Tulsky J, Chesney M, et al. HIV seroprevalence among homeless and marginally house adults in San Francisco. Presented at the annual meeting of the APHA, Indianapolis, Nov.1997.

   Bangsburg D, Tulsky JP, Hecht FM, Moss AR. Protease inhibitors in the homeless. *JAMA* 1997; 278:63-65.

   Bangsburg D, Zolopa AR, Bamberger J, et al. Protease inhibitors (PI) in HIV-infected homeless adults. Presented at the annual meetings of the APHA, Indianapolis, Nov.1997.

   Zolopa AR, Hahn JA, Gorter R, et al. HIV and tuberculosis infection in San Francisco's homeless adults. Prevalence and risk factors in a representative sample. *JAMA* 1994; 272:455-61.

6. Carl Word. Seroconversion Among Crack Smokers in San Francisco. Presentation

   Word C. Multicenter Study of Crack Cocaine and HIV Infection.

   Chaisson RE, Bacchetti P, Osmond D, et al. Cocaine use and HIV infection in intravenous drug users in San Francisco. *JAMA* 1989; 261:561-565.

   Fullilove MT, et al. Risk for AIDS in multiethnic neighborhoods in San Francisco, California. *West J Med* 1992; 157:32-40.

7. Joe Catania. Estimating Population Size of MSM in San Francisco. Presentation

   Binson D, Michaels S, Stall R, et al. Prevalence and social distribution of men who have sex with men: United States and its urban centers. *Journal of Sex Research* 1995; 32(3):245-254.

8. Osmond, D.

   Osmond D, Page KA, Wiley J, Garrett K, Sheppard HW, Moss AR, Schrager L, Winkelstein W Jr. Human immunodeficiency virus infection in homosexual/bisexual men, ages 18-29: the San Francisco Young Men's Health Study, *Am J Pub Health* 1994; 84:1933-1937.

   Osmond DH, Charlebois E, Page-Shafer, KA, et al. HIV seroconversion rates in the San Francisco Young Men's Health Study: 1993-1996. 11th International Conference on AIDS, Vancouver, July 1996.

Lemp, G, Hirozawa AM, Givertz D, et al. Seroprevalence of HIV and risk behaviors among young homosexual and bisexual men: The San Francisco/Berkeley Young Men's Survey. *JAMA*, 1994; 272:449-454.

9. Sally Blower. Modeling HIV Incidence Among San Francisco MSM. Presentation

Blower S. HIV Transmission in Sexual Networks; An Empirical Analysis, Proceedings of the Royal Society London Series B, 1995, #260, 237-244.

Blower S. Linked HIV Epidemics in San Francisco, *Journal of AIDS and Human Retrovirology*, 1996, Vol 11,311-313.

Blower S. Calculating the Odds of HIV Infection Due to Sexual Partner Selection, *AIDS and Behavior*, in press.

10. Susan Buchbinder. HIV Seroincidence in Cohort of High-Risk MSM in San Francisco. Presentation

Buchbinder, SP. Feasibility of Human Immunodeficiency Virus Vaccine Trials in Homosexual Men in the United States: Risk Behavior, Seroincidence, and Willingness to Participate. *JID,* 1996, 174 (November), 954-961.

11. Alex Kral. HIV Prevalence Among Street-Recruited IDUs in San Francisco. Presentation

Kral AH, Molnar BE, Booth RE, Watters JK. Prevalence of sexual risk behavior and substance use among runaway and homeless adolescents in San Francisco, Denver and New York City. *International Journal of STD and AIDS*, 1997 Feb, 8(2):109-117.

Watters JK, Bluthenthal RN, Kral AH. HIV seroprevalence in injection drug users (letter). *JAMA*, 1995 Apr19, 273(15):1178.

Watters JK, Trends in risk behavior and HIV seroprevalence in heterosexual injection drug users in San Francisco, 1986-1992. *Journal of Acquired Immune Deficiency Syndromes*, 1994 Dec, 7(12):1276-1281.

Watters JK, Estilo MJ, Kral AH, Lorvick JJ. HIV infection among female injection-drug users recruited in community settings. *Sexually Transmitted Diseases*, 1994 Nov-Dec, 21 (6):321 -328.

12. Joe Guydish. Seroprevalence Among Three Cross Sectional Samples of NEP Clients. Presentation

    Guydish J. Evaluating Needle Exchange: A description of client characteristics, health status, program utilization, and HIV risk behavior, Substance Use and Misuse, 1992 seroprevalence data, (in press).

13. Will McFarland. HIV Prevalence and Incidence Among Infants and Children. Presentation

14. Other References

    Katz MHJ, AIDS Epidemic in San Francisco Among Men Who Report Sex with Men: Successes and Challenges of HIV Prevention., *Acquired Immune Deficiency Syndrome*, 1997; 14 (Suppl. 2): S38-S46.

    San Francisco Department of Public Health, Division of STD Control, 1996 STD Reports.

    Moss AR, Vranizan K, Gorter R, et al. HIV seroconversion in intravenous drug users in San Francisco, 1985-1990. *AIDS* 1994, 8:223-231.

Appendix E
1996 HOLMBERG HIV ESTIMATES

Persons living with HIV in San Francisco, San Mateo, and Marin Counties 1996

Population	Prevalent Infections	Incident Infections
Total	25,900	944
MSM	22,000	448
IDU	3,300	374
HET	640	122

Appendix F
1996 HRSA HIV ESTIMATES

Persons living with HIV in San Francisco, San Mateo, and Marin Counties 1996

Population	Prevalent Infections
Total	16,227
MSM	12,880
IDU	2,100
HET	450
Other	877

Appendix G: 1997 HIV CONSENSUS MEETING
Monday, May 12, 1997

AGENDA

8:30-9:00 **Registration and Coffee**

9:00-9:20 **Introductions, Agenda Review, and Structure of Meeting**
George Rutherford, M.D.

9:20-10:40 **Presentations of Data: Cutting across multiple populations**

Warren Winkeistein, M.D. "All Epidemics are local. Dynamics of HJV/MDS in San Francisco

Willi McFarland , M.D., Ph.D. "HIV Prevalence and Incidence Estimates for San Francisco"

Tim Kellogg, M.S. "Overview of HIV Sentinel Surveillance in San Francisco, 1991 - present"

John Newmeyer, Ph.D. "Back Calculation as a Method for Estimating HIV Prevalence and Incidence"

Marjorie Robertson, Ph.D. and David Bangsberg, M.D. "HIV Prevalence in the Homeless and Marginally Housed"

Carl Word, Ph.D. "Seroconversion Among Crack Smokers in San Francisco"

10:40-10:50 **BREAK**

10:50-11:30 **Presentation of Data: MSM, MSM/F**

Joe Catania, Ph.D. "Estimating Population Size of MSM in San Francisco"

Dennis Osmond, Ph.D. "HIV Incidence in the San Francisco Young Men's Health Study"

Sally Blower, Ph.D. "Modeling HIV Incidence Among San Francisco MSM"

Susan Buchbinder, M.D. "HIV Seroincidence in Cohort of High Risk MSM in San Francisco"

11:30 - 12:30 **Discussion of Data and Vote on Estimates - MSM, MSM/F**
Including discussion of estimates by sub-populations at potentially higher or lower HIV prevalence or incidence

12:30 - 1:00 **BREAK + LUNCH**

1:00-1:30 **Presentation of Data: IDUs**

Alex Kral, M.S. "HIV Prevalence among Street-Recruited IDUs in San Francisco"

Joe Guydish, Ph.D. "Seroprevalence among Three Cross Sectional Samples of NEP Clients"

1:30 - 2:20 **Discussion of Data and Vote on Estimates - IDUs**
Including discussion of estimates by sub-populations at potentially higher or lower HIV prevalence or incidence

2:20 -3:10 **Review of Previously Presented Data, Discussion and Vote on Estimates Women and Heterosexual Men**
Including discussion of estimates by sub-populations at potentially higher or lower HIV prevalence or incidence

3:10 - 3:20 **BREAK**

3:20-3:30 **Presentation of Data: Infants and Children**

Willie McFarland, M.D., Ph.D. "HIV Prevalence and Incidence among Infants and Children"

3:30-3:50 **Discussion of Data and Vote on Estimates - Infants/Children**

3:50-4:20 **Discussion of Data and Vote on Estimates for Overall Population**
Including discussion of estimates for other populations not covered above.

4:20-4:50 **Review of Votes and Gaps in Votes**

4:40-5:00 **Conclusion and Next Steps**